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An Exploration of the Experiences of Mentors Supporting Clinical Skills' Development in Student Nurses in Very Remote Rural Scotland

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Doctorate in Education (EdD)

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Abstract

This study explores the experiences of mentors working with student nurses in a very remote rural setting in Scotland. Student nurses' clinical skills' development and acquisition is the responsibility of the mentor in practice, with the mentor being viewed by the Nursing and Midwifery Council (NMC) as the ultimate gatekeeper into their profession, due to their specific role in assessing students. However, there is a dearth of research undertaken within the UK context that focuses upon clinical skills' teaching by mentors in clinical practice and, specifically, within the Scottish and very remote rural context. This study sought to determine what nurse mentors consider to be the clinical skills that they teach student nurses and how they teach these in clinical practice.

A case study approach was used to provide a rich narrative, illuminating the experiences of mentors in this setting. Three focus groups of mentor teams working in community settings in one very remote rural Health Board in Scotland outlined their experiences of supporting pre-registration nursing students, all of whom were living and working away from their home or main university campus.

The key findings of this study revealed that mentors use a wide range of 'scaffolding' behaviours to teach clinical skills in practice, and that they were influenced by the mentor preparation programmes they had undertaken prior. Furthermore, the mentors in this study did not distinguish between psychomotor skills as being clinical skills but deemed all care to be clinical skills. Another key finding highlighted the needs of student nurses when faced with the challenges of learning to nurse in this environment and has shown that aspects such as geography, environmental factors, communication, and the nature of health care provision have important effects, not only on the mentor role but also on the support students require in practice. Furthermore, the concept of the 'triad' relationship between student, patient and registrant is suggested and a model of learning in community practice that recognises that this relationship is central for student nurse learning is introduced. This model acknowledges the influence of both physical and social geography on student learning in practice.

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I am so extremely grateful to the participants of this study for sharing their experiences. It is my hope that this study will not only contribute to an evidence base recognising the influence of physical and social geography on student learning in practice, but will also act as a conduit to showcase the amazing work of registered nurses supporting student nurses in clinical practice in very remote rural Scotland.

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Chapter 1 Introduction

1.1 Introduction

This study has examined the experiences of a group of mentors living in a very remote rural area of Scotland, with a specific focus on their experiences of teaching clinical skills to student nurses who are undertaking their practice placement with them in their clinical practice areas. The mentors in this study were practicing within a community setting, and supervising and assessing pre-registration nursing students, all of whom were living and working at a significant distance from their Higher Education Institution of study. This meant that the students were at least 60 miles from their campus and their journey involved not only a car journey but either a ferry crossing or a flight. All the students were required to live away from their usual place of residence for a minimum of five weeks. Using a case study approach and through focus groups, mentors living and practicing in an area of Scotland categorised as 'very remote rural' participated in this study.

This introductory chapter seeks to explain the rationale for and personal interest in this topic. It also outlines the context of nurse education in the UK and how mentorship came to be an integral role within the pre-registration nursing and midwifery teaching team. The term 'very remote rural Scotland' will be defined, and a more in-depth explanation and rationale for this being a key context of this study is presented. The thesis structure is also provided and finally the aims of the research along with the specific research questions are set out.

1.2 Background

The lack of research undertaken into mentors' experiences of teaching students in their clinical areas had become clear through a literature review undertaken as part of my role as a Practice Education Facilitator, supporting nurse mentors in practice. Indeed, whilst there is research that looks at the support needs of mentors themselves and their experiences of supporting failing students in practice, mentors' experiences of teaching clinical skills are largely underrepresented. It can be argued that the student voice is heard but the mentors' voice is largely ignored and, therefore, I decided that the key focus of my research would be to find the mentor voice. I wanted to ascertain what mentors considered to be the key clinical skills that they taught student nurses in practice and how mentors teach clinical skills in practice. The concept of very remote rural nursing and community placements is also of particular interest to me, having lived and worked in a very remote rural community in Scotland for most of my life. An additional reason for this research is that there appears to be a gap in knowledge that exists regarding mentorship in very remote and rural communities. Most of the existing research is based in other countries such

as Canada, America and Australia, with very little concerned with the particular considerations of Scotland.

1.3 Rationale for the research

The Scottish Government (2016, p.5) defines very remote rural areas of Scotland as being

‘Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more’.

The NHS Board area in which this study was undertaken comes under this definition (see Appendix 1). Countries such as Canada and Australia have very similar definitions, as much of the literature concerning the very remote rural aspects of mentors’ experiences of supporting student nurses in clinical practice comes from these two countries (Bourke et al, 2012; Place et al, 2014). Whilst there are a few published UK evaluations of medical students’ experiences of rural clinical practice, these are limited and focus on how experiences may or may not tackle recruitment issues in these areas (Wolstencroft and MacVicar, 2011). Wisdom (2011) is the only study found to date that has focussed on mentors in remote and rural areas within the UK.

There are 34 people/km² in Europe, 65 in Scotland, but in the Highlands and Islands it is only 8 people/km². This is the lowest population density in the United Kingdom and one of the lowest in Europe. The Highlands and Islands of Scotland are made up of four NHS Boards, all of which consist of areas that are categorised as very remote rural. Certain areas of the Highlands and Islands are on a par with areas of northern Finland and Sweden with regards to their rurality. Furthermore, the Highlands and Islands of Scotland is one of the most sparsely populated areas in Europe. Very remote rural areas in Scotland have fewer economic opportunities compared with rest of the UK, lack robust transport and communications infrastructure and, as such, remain highly dependent on service industry employment with health services and local councils being the main employers. Gould and Moon (2000) identified what they considered to be a ‘penalty’ in service provision, especially in very remote rural island communities. They found that the level of service provision can never be equal to that of urban and less rural areas, due to the demands of providing services with less resources. Population numbers may be very low with a relatively high proportion of elderly people, coupled with fluctuating numbers of tourists to cater for at certain times of the year. Thus, the human resource provision needed to deliver adequate health and social care can be difficult to maintain at levels necessary for the numbers of the population and changing demand. Furthermore, there are additional costs associated with location such as transport costs (e.g. ferry and plane) as well as paying incentives to recruit and retain professionals to deliver services. Just as those residents in certain areas of London are provided with extra incentives, many island communities across Scotland will pay public sector workers a

‘distant islands allowance’. This is important as evidence has shown that average earnings are less in very remote rural communities and that the cost of living is higher (Farmer et al, 2003). Just as a higher rating is required to address the cost of living in London, the distant islands allowance is in place to address the higher costs to people living in very remote and rural communities. These include higher prices for groceries and other staples such as fuel due to the extra costs involved in transporting goods to very remote and rural communities.

Rural nursing is defined as *‘the provision of health care by professional nurses to persons living in sparsely populated areas’* (Winters, 2013, p.1). Furthermore, the Australian literature reviewed often defines rural nursing as including nurses who work out with a major metropolitan area where the population has reduced access to health services (Mills et al, 2010). Rural nursing is not only defined by geography but also by role. Hounsgaard et al (2013) identified that nurses in remote and rural Arctic areas performed a wide-ranging role. Nurses practising in these locations are not solely considered to be generalists, but they are also expected to fulfil some aspects of the roles undertaken by medical and social work professionals in more urban areas. Nurses in remote and rural areas in Australia also fulfil a wide range of roles. Hegney (1996, p1) coined the phrase ‘a jack of all trades’ when undertaking a review of the nature of nursing work in such areas of Australia and this wide ranging role continues, with Mills et al (2010) further quantifying that the more remote the geography of practice, the more generalist the role of the nurse becomes. Not only do rural nurses in Australia work in remote geographical locations, such as isolated areas and islands, but they also work with remote populations. These are communities with groups of people who are either specific in their occupation, for example farming, or specific to their ethnicity and culture. More often than not these groups also reside in the more isolated areas of Australia. Australian rural nurses traditionally have lived and worked within railway and mining communities as well as indigenous communities (Lenthall et al, 2011). This is also the case in very remote rural communities of Canada and North America, where nurses are also working with isolated cultures who also happen to live in isolated geographical locations. In these countries, as well as in Australia, nurses are expected to perform a generalist role as well as fulfilling other roles beyond health and social care at times if necessary (Leipart et al, 2012; Long and Weinart, 2013). All of these aspects are common to the role and as will be shown the experiences of nurses working in very remote rural areas of Scotland.

Studies have found that nurses working in very remote rural areas of Scotland also perform a generalist role (Lauder et al, 2001; Farmer et al, 2002). Their findings were based on research undertaken in the Highlands of Scotland and the authors themselves were resident in Scotland. However, there is very little evidence or studies available that provide more up to date data surrounding the role of the nurse working in these communities in Scotland or the UK from 2003

onwards. What is clear is that the evidence from UK literature identifies that some of the generalist aspects of the role of the rural nurse are undervalued and at times go unrecognised. For example, Lauder et al (2001) found that because the role of the rural nurse can often involve tasks that are difficult to quantify, they can go unrecognised and at times nurses reported hiding work such as preventative proactive visits to vulnerable people in their communities as line managers did not see these visits as their job. It was reported that line managers supervising at a distance did not see this preventative work as vital. It is important to consider this when discussing the role differences that may occur due to a difference in working location, especially the fact that nurses may find themselves expected to work across 'fields' of nursing for which they are not trained, or registered for on the NMC register. Nurses within the UK are trained to be field-specific before registration. This means that nurses work with a specific population group, such as adults, children and young people, people with a learning disability or people with mental health needs, and they undertake a three year degree programme, which results in registration specific to one of the groups.

On the other hand, in Canada, there are three options – midwifery, general nursing, or psychiatric nursing. In most other countries, nurses specialise after initial training and not all countries require a degree as a minimum qualification. Historically in Scotland, in many of the very remote rural communities, there have been double or even triple duty nurses. These were nurses who, following initial training and consolidation of practice, furthered their studies in order to achieve other field qualifications. Most common would be the nurse who was also a qualified midwife and, on some of the more remote islands, especially in the Northern Isles of Scotland, nurses will still be found who are both midwives and health visitors. This role evolved in these communities, following the introduction of the Highlands and Islands Medical Service in 1913. This was a state funded healthcare service that, whilst not free, did ensure that healthcare services were provided in areas where previously this had been lacking and was a direct result of the Dewar Report of 1912 (BMA, 2012). However, since 2010, it has been a requirement that nurses must have a degree level qualification as a minimum and this led to the cessation of 'conversion' programmes, whereby nurses could add another field by attending a programme of 18 months. This was known as a 'top up' programme. This has resulted in increased issues in providing more specialised nursing services such as midwifery, health visiting and mental health to very remote areas as the double and triple duty nurse role has all but disappeared, due to lack of opportunities for nurses to train to fulfil these roles, as well as pressures on health services. No longer can health boards afford to provide 24/7 cover and, as such, without dual trained nurses these services may not always be available.

1.4 Personal interest in the research topic

When I began this study, I was working in a practice education role for a very remote rural NHS board in Scotland. The key aspect of this role was supporting mentors working with pre-registration students of nursing and midwifery on clinical placement within their clinical area. Not only did this involve providing support and advice to nursing and midwifery mentors and their colleagues, but also delivering the mentor preparation course, often in the more remote areas and at a distance from the partner Higher Education Institution (HEI) campus. This entailed round journeys of six hours in total, by car and ferry, to meet with the mentors, with a total return mileage of 286 miles.

The role of the mentor within nurse education is a very important and influential one, as students spend 50% of their course in clinical practice with a mentor. It is during this time that much of their learning takes place and it is the mentor that is the prime influence in the student's learning. Not only does the mentor support, facilitate, and supervise learning but they are also responsible for assessing students within the clinical area. In my previous role and my current role as a Lecturer in Adult nursing (which I commenced in December 2017) I was involved in delivering the mentor preparation course. This is the module that allowed registered nurses to become mentors to student nurses and midwives and includes considerable theoretical content with regards to teaching and assessment practices within the workplace. During this study, the Nursing and Midwifery Council introduced new Standards for student supervision and assessment (NMC, 2018b) and the implications of these in line with the study findings are discussed further in chapter 6.5.

I had previously undertaken research into the scaffolding behaviours of mentors for my Master's degree in Education and had initially thought to further expand on this as I was interested in how mentors teach students in clinical practice. At the beginning of my research for this current study, I undertook a literature review concerning this aspect of the role. However, as my research journey developed, I found myself more interested in the experiences of mentors' teaching clinical skills within practice, not just how they taught clinical skills in practice but learning more about their personal experiences. Also, more specifically, I was intrigued by how mentors in very remote rural community settings teach students and, in particular, how they effectively support students in locations away from their main learning centre (campus of their Higher Education Institution), which requires the students to live for a period away from their main term time address.

1.5 Nurse education and practice context

Up until the 1990s, nurse education was predominantly delivered via schools of nursing within teaching hospitals. Nursing degrees have been in existence since the first nursing degree course offered by the University of Edinburgh in 1956 but, in the main, nursing training was undertaken using an apprenticeship model by which student nurses were an integral part of the ward workforce and received a salary. Under this model, student nurses learnt through direct observation and practice in the clinical settings. Assessment was undertaken through ward based practical tests and a national written examination (Eaton, 2012).

With the introduction of Project 2000 in the UK in 1989 (Allen, 2009), this changed significantly, with nursing education coming under Higher Education Institutions (HEIs). Students were no longer salaried members of the workforce but receiving bursaries and supernumerary whilst in practice. A minimum of a Diploma in Higher Education was awarded to registrants completing this programme and the focus changed to a health rather than an illness model to reflect a change in the way health professionals were delivering care (Royal College of Nursing, 2007). A more personalised, holistic approach to delivering care was beginning to be introduced. Prior to this time, student nurses were supervised in practice but were not assigned a designated mentor who had been prepared specifically for this role. Project 2000 introduced a formal mentorship model which became integral to students' learning whilst on clinical placement and therefore all nursing and midwifery students in training from 1997 onwards will have had a formal mentor relationship with an allocated mentor whilst in practice (Murray and Staniland, 2010).

In 1999, the UKCC (United Kingdom Central Council for Nurses, Midwives and Health Visitors), which was the predecessor to the NMC, produced the report 'Fitness to Practice' (UKCC, 1999). The investigation for this report was headed by Sir William Peach and it corroborated previous studies' findings which had demonstrated that sometimes nurses were qualifying without certain key practical skills (Maben and Macleod Clark, 1998; Runciman et al, 1998). The UKCC's 'Fitness to Practice' report resulted in key changes to the nurse education programme in the UK. These changes consisted of the reduction of the Common Foundation Programme from 18 months to 12 and a greater emphasis on clinical skills at an earlier stage in the programme. Interestingly, whilst the changes were implemented, failure to fail and thus the issue of newly qualified nurses having deficits in key skills remained.

This was highlighted by Dr Kathleen Duffy, who was funded by the Nursing and Midwifery Council (NMC) in 2003 to look at the factors which influenced the assessment of students' competence to practice. Duffy's research introduced the term 'failing to fail', which is well known in nursing and

midwifery practice education today (Duffy, 2003). This term is used to describe the situation when a registered nurse or midwife passes a student in practice, despite having concerns about their abilities and with the student obviously failing to meet the required standards. In Scotland, Practice Education Facilitators were introduced in 2004 as a direct result of this report. All students must be assigned a named mentor whilst undertaking the practice element of their programme. In the UK, the term 'mentor' has been chosen for those registered nurses and midwives who take on the role of working with students, providing support and guidance, as well as assessing that student at the end of their clinical placement (Mead et al, 2011). From 2006, clear standards for mentors were introduced and an integral aspect of the new standards was the introduction of a single developmental framework that mentors worked to towards, in order to achieve 'mentor' status (NMC, 2006). These standards were introduced by the NMC in 2006 and, subsequently, there was a further update in 2008 (NMC, 2006; NMC, 2008). The purpose of these standards was to ensure that student nurses had access to quality mentorship throughout their clinical placements and it was hoped that the introduction of these standards would go some way to tackling the 'failing to fail' issue. These standards brought the requirement for the first time in the UK for all new mentors of student nurses to have undergone formal mentor preparation prior to undertaking the role. The NMC (2008, p19) defined a mentor as 'a registrant who following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an HEI as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes'.

Within the Scottish context, there were clear guidelines produced by NHS Education for Scotland for mentor preparation programmes contained within the National Approach to Mentor Preparation for Nurses and Midwives (NHS Education for Scotland (NES), 2007). The second edition of this document was released in 2013 and outlined the core curriculum it expected to be covered in the mentor preparation courses provided by all HEIs who deliver the pre-registration nursing programme across Scotland (NES, 2013). Previous to the national approach, mentor preparation courses existed but there were no guidelines to prescribe content or duration, so course providers were at liberty to deliver variable content.

The Willis Report (Willis Commission, 2012), commissioned by the Royal College of Nursing, sought to determine what excellent pre-registration nursing education in the UK should look like and how it should be delivered. The Willis Commission also identified that the quality of many practice learning experiences required urgent improvement and recommended that mentors be selected for knowledge, skills, and motivation. Furthermore, they suggested that there may have been some issues with the adequacy of the mentor preparation programmes and, as such, this

raises the question as to whether there are areas missing in the current mentor preparation programmes. The Francis Report (Francis, 2013) came from the Mid-Staffordshire NHS Foundation Trust Public Enquiry, which investigated failings at Mid-Staffordshire NHS Trust. This enquiry was convened to look at specific aspects of patient care within this trust. However, the report included recommendations of relevance to pre-registration nursing education.

There has been a growing agenda over the past two decades to ensure that mentors are accurately assessing students in order to tackle the ‘failing to fail’ (Duffy, 2003). Mentors are being asked to act as gatekeepers to the profession and this has become increasingly important since the publication of the Willis (2012) and Francis (2013) reports. However, whilst it is clear that nurse mentors in the UK are expected to be both teachers and assessors, it seems that the focus of mentors is on the assessment and supervision aspects, as will be demonstrated in the literature review chapter.

There is much emphasis on how crucial the mentor is for students whilst undertaking the clinical practice element of the course. The Nursing and Midwifery Council’s (NMC) (2008, p9) definition of a mentor that is still currently in use is:

‘a registrant who following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an HEI as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes’.

The NMC (2008) *Standards to Support Learning and Assessment* outline the six domains and, within each domain, key learning outcomes that mentors must demonstrate achievement of before mentoring student nurses and midwives in practice. The specific responsibilities of the mentor are shown in Table 1:

Table 1: Specific responsibilities of the mentor

Specific responsibilities of the mentor (NMC, 2008, pp. 23 – 24)
<ul style="list-style-type: none"> • Organising and coordinating student learning activities in practice • Supervising students in learning situations • Providing constructive feedback • Setting and monitoring objectives • Assessing students’ skills and attitudes and behaviors’ • Providing evidence of student achievement • Liaising with others about student performance • Identifying concerns • Agreeing actions about concerns

However, the role of the mentor remains far from clear and it is multi-faceted. Casey and Clark (2011) have pointed out that general definitions other than the standard NMC (2008) definition appear in the literature and all seem to include words such as 'guide', 'friend', 'advisor' and 'supporter'.

The role of the mentor within the UK is to undergo change as from September 2020, with the first intake of pre-registration student nurses to embark upon a new programme of education. In May 2018, the NMC launched their document '*Future nurse: Standards of proficiency for registered nurses*' (NMC, 2018a). These standards have been produced to ensure that standards of proficiency for the registered nurse reflect today's nurse and the nurse of the future in so far as they aim to be more contemporary and up to date. In addition to these new standards of proficiency, a new model of practice supervision and assessment is set to be implemented from 2020 onwards. The title 'mentor' is to disappear and is to be replaced by practice 'supervisor' and practice 'assessor' (NMC, 2018b). These changes will separate the two aspects of the current mentor role of supervisor and assessor. Supervising mentors will no longer need to have undertaken a formal university accredited mentorship course as long as they are suitably prepared for the role. NHS Education for Scotland (2019) have produced a National Framework for the implementation of these new standards throughout Scotland and this includes guidance on how practitioners will be developed to fulfil these roles.

1.6 Research aim and questions

The aim of this research is to explore the experiences of nurse mentors in a very remote rural area of Scotland. The enquiry focusses on those experiences relating to their teaching of clinical skills to student nurses in a type of geographical location for which very little research has been undertaken to date. Therefore, it attempts to fill a gap in the knowledge base relating both to clinical skills teaching and mentors' experiences of teaching clinical skills in very remote rural areas.

The key research questions that the research aims to answer are:

1. What are the mentors' experiences of teaching clinical skills in a very remote rural area of Scotland?
2. What do nurse mentors consider to be the clinical skills that they teach student nurses?
3. How do mentors teach these clinical skills in practice?

This is with a view to ascertaining how these findings inform current pedagogical thinking with regards to nurse education in clinical practice, as well as determining whether they are aligned

with mentors' experiences as recorded in previous research studies to date or whether there are significant differences.

1.7 Thesis structure

The thesis consists of six chapters. Chapter 1 has provided an introduction and background to the study. In this chapter the rationale for the choice of the research topic has been given, thus offering an insight into my personal interest in practice education in nursing. This has been set within a context of background information regarding the recent historical and current climate of practice education in nursing and midwifery.

Chapter 2 provides a review of the literature and specifically focusses on educational theory applicable to nurse education, nurse education in practice within the UK context and experiences of learning and teaching in clinical practice. Literature from other areas of the world with similar models of practice supervision and assessment of student nurses has also been included in the review, for example, from Canada, Australia, and the USA. This chapter begins by outlining the strategy for the literature review including how the search criteria were decided upon.

Chapter 3 describes the research methodology, design, and methods of data collection. This includes a discussion of the epistemology and ontology, the rationale for the chosen design, sample, methods of data collection and analysis, ethical considerations, and the implications of practitioner research.

Chapter 4 presents the finding of the research. The insights and experiences of the mentors who participated are outlined in detail, using direct quotes and observation of group behaviours.

Chapter 5 discusses how these findings relate to existing research and contribute to current knowledge.

Finally, chapter 6 offers conclusions and recommendations for practice, policy and research. In this chapter a summary of the main findings is offered, as well as identifying questions worthy of future research and scrutiny.

1.8 Summary

This chapter has provided an outline of the research aims and objectives of this study, as well as delivering an overview of the current climate of practice education with regards to nursing and midwifery and how this has evolved. The rationale for the choice of research question has been

described as well as information supporting the personal interest in the research topic. Chapter 2 now explains the process used for the literature review and presents the findings.

Chapter 2 Literature review

2.1 Introduction

This chapter outlines the literature review that was undertaken for this research. The process is described as well as the key findings from the literature reviewed. The primary purpose of the literature review was to discover the current knowledge base, identify any gaps in that knowledge base, sharpen the research questions and identify the methodologies used by others when investigating similar research questions.

As mentioned in chapter one, one of the reasons for undertaking this study was the paucity of literature concerning mentors' experiences of teaching clinical skills to student nurses in clinical practice. This had been identified in a previous literature scoping carried out as part of my role in practice education.

2.2 Search strategy

Prior to commencing the literature review for the study, it was decided not to limit the age of research included and this was for two reasons. Firstly, the concept and term 'mentor' has not been in use historically for a substantial length of time though it is difficult to pinpoint an exact time when this term was first used. To ensure a robust search that could identify any relevant research it was important to ensure that nothing pertinent was missed, especially as it was already established early on in the process of planning this study that there was a potential lack of research. Secondly, if the search was limited by year of publication, there was the possibility that research relating to educational theory may be missed as the educational theory related to nurse education often evolved in the middle and late twentieth century.

Various search engines were used to access literature via the Open University library platform and the Knowledge Network (www.knowledge.scot.nhs.uk), which is an online resource available to all NHS staff in Scotland. The search engines included CINAHL plus; Medline; OVID; BNI; EBSCO; Science Direct and Google Scholar. The terminology relating to mentorship is wide and varied and the search terms were focussed on the following search terms: mentor; mentorship; preceptor; preceptorship; practice supervisor; clinical supervisor; student nurse; pre-registration student; placement; placements; practice learning; clinical practice; clinical skills; and clinical skills teaching. The decision was made to limit the search to these terms in the first instance with the expectation that educational theory would be inherent in many of these articles and this was the case. The literature search was not limited to the UK in this first round of searching and this was done intentionally in order to scope a larger result. This produced 58,866 hits in this first initial search. See Table 2:

Table 2: Literature search strategy and results table

Literature search strategy and results table	
Inclusion criteria	Exclusion criteria
<ol style="list-style-type: none"> Search terms: <ul style="list-style-type: none"> Mentor Mentorship Preceptor Preceptorship Practice supervisor Clinical supervisor Student nurse Pre-registration student Placement (s) Practice learning Clinical practice Clinical skills Clinical skills teaching Search engines: <ul style="list-style-type: none"> CINAHL Plus Medline OVID BNI EBSCO Science Direct Google Scholar English language Worldwide Sources <ul style="list-style-type: none"> Textbook Peer-reviewed articles 	None
Total results: 58,866	

In order to pare this down a Boolean search using the term nurs* and mentor* and “experiences” and “clinical skills” and “clinical practice” and “student nurse” OR “student midwife” was undertaken and it produced 213 hits. This was important to ensure that the literature reviewed was capturing the experience of mentors working with student nurses and/or student midwives.

Table 3: Boolean search strategy (literature search phase 1)

Boolean search strategy (literature search phase 1)	
AND	OR
Nurs*	
Mentor*	
'experiences'	
'clinical skills'	
'clinical practice'	
'student nurse'	'student midwife'
Total results: 213	

Once the literature was identified via the above process, the remaining articles were then analysed in more depth. As previously mentioned, one of the main reasons for this study was the dearth of literature available that provides mentors' experiences of the mentoring role and specifically teaching clinical skills in practice. It was also evident from this initial literature review that there was a significant lack of research that had been undertaken in the specific geographical contexts of Scotland and/or remote and rural communities. This prompted further searching in a second phase, using the specific terms of 'remote' and 'rural' and 'Scotland' when it became clear that this was needed. No hits were discovered for 'remote and rural' and 'remote and rural' AND 'Scotland'. When the terms 'Scotland' and 'remote and rural' were removed, 42 hits were obtained. However, only nine of these articles were specifically situated within Scotland and only two were related to practice only as well as being from the experiences of the student and not the mentor. The search terms of 'community', 'district' and 'primary care' were also added at this point in an attempt to increase the possibility of finding research concerned with remote and rural communities as within these communities there may not be in-patient or hospital services and so nursing would be taking place within the community. The term "Scotland" and "remote and rural" was removed to widen the scope. This search produced 30 hits but none of these related to Scotland or Remote and Rural, so this was discarded, and the 42 articles were reviewed. See Table 4:

Table 4: Boolean search strategy (literature search phase 2)

Boolean search strategy (literature search phase 2)	
AND	OR
<p>Nurs*</p> <p>Mentor*</p> <p>'experiences'</p> <p>'clinical skills'</p> <p>'clinical practice'</p> <p>'student nurse'</p> <p>'remote and rural'</p> <p>'remote and rural' AND 'Scotland'</p> <p>Total results: 0</p>	<p>'student midwife'</p>
<p>Nurs*</p> <p>Mentor*</p> <p>'experiences'</p> <p>'clinical skills'</p> <p>'clinical practice'</p> <p>'student nurse'</p> <p>'remote and rural'</p> <p>Total results: 42</p>	<p>'student midwife'</p>
<p>Nurs*</p> <p>Mentor*</p> <p>'experiences'</p> <p>'clinical skills'</p> <p>'clinical practice'</p> <p>'student nurse'</p> <p>'remote and rural'</p> <p>'community'</p> <p>'district'</p> <p>'primary care'</p> <p>Total results: 30</p>	<p>'student midwife'</p>

All these results were included in the initial literature review to allow for more in-depth analysis. In total, 213 papers were found for the literature review during first search and then a final number of 42 were reviewed for the purpose of this study.

In terms of the analytical process for the literature review, this was in part informed by the concepts emerging from previous research on scaffolding behaviours, as described in the first chapter (Section 1.4), and the research questions (Section 1.6). These in turn had impacted the choice of search terms, which were the basis for the first and second phases of the literature review (see Tables 3 and 4). Thus, at this point in the research, existing themes were evident. In order to take these themes on further, and to add to them, the following inductive approach was adopted. All of the selected papers were read, sometimes several times, in order to extract the concepts, insights and findings, as well as to make judgements as to their quality and relevance to the topic. Then once these were collated, they were grouped into the key themes. This also allowed for the gaps in the literature to be identified and for new and nuanced theoretical positions to be identified. Thus, the literature review was used to affirm the key *apriori* theory of practice learning, to expand upon it, to clarify the robustness of existing knowledge and to provide indicators as to how this could be applied in practice.

Initial scoping of the literature reviewed found that several key aspects of practice learning had previously been examined and researched and these form the structure of this literature review. They include educational theory and how this is applied to current models of nurse education in the practice setting. Much of the recent research on student learning in practice has focussed on the student experience of learning and being 'mentored' in practice. There is much less emphasis on the experiences of mentors in this regard. Research on clinical skills teaching and facilitation of clinical skills teaching for students by mentors is very scarce, but a few studies do provide some insight. The experiences of mentors supervising students in community settings has been examined but there is a lack of research with regards the remote and rural or very remote rural setting and the Scottish context. There were a number of themes that emerged from the literature review, and these are highlighted below.

2.3 Educational theory and nurse education in practice

Cognitive apprenticeship, legitimate peripheral participation, and scaffolding feature heavily throughout the literature concerned with the theory of student nurse learning during placement. In 1998, Jenny Spouse published papers on these topics. She argued that legitimate peripheral participation is crucial to effective education of the student as well as effecting a greater sense of belongingness (Spouse, 1998a). She theorised from anthropological and educational studies she

had previously undertaken that legitimate peripheral participation was applicable within the nursing community as well as in other settings. This was a term coined by Lave and Wenger (1991) and it is concerned with the process by which a person, usually a newcomer, integrates into and becomes part of a community of practice. This is done through situated activities, especially learning on the job with the assistance of a sponsor who aids this transitional process into becoming a member of that community of practice. It is clearly akin to the process by which nursing students develop the clinical skills and knowledge required to become a registered practitioner under the current UK model, as outlined in chapter one.

Legitimate peripheral participation sits within the cognitive and sociocultural theories of education and fits within Vygotsky's work. Vygotsky (1978) held the view that at the heart of learning and social and cognitive learning was social contact. In contrast to Piaget, who considered social development to be dependent on physical development, Vygotsky believed that social interaction was the key to social and cognitive development (Spouse, 1998b). Vygotsky developed the term *Zone of Proximal Development*, which is a two-stage theory of development. The learner has existing knowledge in one zone and then an outer zone which is the area of potential development. Vygotsky (1978) believed that it was through the use of interpersonal speech (language interaction between teacher and learner) and intrapersonal speech (language interaction where learner vocalises to self or teacher knowledge) that there can be movement across the zone. Wood et al (1976) used the term *scaffolding* to describe the process by which a more knowledgeable individual assists a learner through interaction. This arose from a study of 30 children who were assisted by 'tutors' in tasks. They found that the children rarely mimicked the actions of the tutor but, through signposting and directing the children towards problems, they came to undertake the task through problem solving and the use of applying knowledge to practice.

Scaffolding as a concept is widely written about in nursing academia and there is literature available which examines its place in clinical learning. It is clearly advocated as a crucial element in effective clinical teaching for student nurses whilst on placement (Owen, 2009; Harrison, 2010; Valdez et al, 2012; Chambers et al, 2013). Valdez et al (2012) looked at scaffolding behaviours and carried out a study to identify these, as well as students' perceptions of this. They divided the behaviours into thought-provoking moves which consisted of questioning the students' knowledge, focus-steering moves which consisted of orientation and demonstration, as well as correcting behaviour and action-enabling moves which include instructing and guiding students as they are carrying out clinical skills. They also identified the need to withdraw the 'scaffold' and allow students to practise the clinical skills with minimal or indirect supervision. In order to deliver

effective scaffolding, the teacher needs to provide clear direction, reduce any confusion about what is required and clarify the purpose of the teaching. In addition, they need to attempt to keep the student focussed on the task, signpost effective resources and inspire the learner to increase their knowledge and understanding. Valdez et al's (2012) study focussed on the student nurse's identification of scaffolding behaviours and was limited to these in relation to one specific area of nursing practice, this being medicine administration. There were 31 participants, and this study was carried out in the Philippines. However, unlike most of the literature reviewed, this was an actual research study based on clear findings and as such had merit in indicating the nature of learning.

Andragogy versus pedagogy also features within literature relating to educational theory pertinent to nurse education. Andragogy or use of the Andragogical Model, as defined by Knowles (1984, p9), is the preferred term for teaching and is a model which regards the adult learner as self-directed as opposed to the pedagogical model which assumes that the teacher decides and directs the learner. Pedagogy is the term associated with the education of children, although Knowles did make it clear that both approaches to education and training can be useful for both adults and children alike.

Interestingly there has been debate as to which approach nurse education adopts as it can be assumed that, as nurse education takes place within an adult education environment, this would naturally follow the andragogical approach. However, on the one hand, Mackintosh-Franklin (2016) suggested that, due to nursing education's traditional non HEI background, it has always adopted the pedagogical approach, stating that this is because pedagogy is usually associated with outcomes, particularly competency-based outcomes. Mackintosh-Franklin (2016) asserted that this was because nursing education is predominantly content driven and led by academic staff.

Prior to this, and on the other hand, Hughes and Quinn (2013) had suggested that the andragogical model is highly applicable to current nurse education programmes, particularly as one of the central facets of this model is the mutual planning of learning. A key aspect of student nurse learning whilst on clinical placement is that the mentor and student plan learning opportunities and goals together, based on the student's self-appraisal of learning needs for the placement. Despite this, both Horsfall et al (2012) and Welch (2011) identified that nurse educators continue to concentrate on skills and knowledge acquisition, focussing on the use of measurable outcomes to assess learning. One reason suggested as to why this continues to be the case is that high student numbers result in a dependence on nurse educator led approaches (Carr,

2008), although Zepke et al (2006) proposed that a more student centred approach may help improve retention of students and reduce attrition rates.

Milligan (1997) had suggested that andragogy was an important model for nurse education as it is aligned with the nature of nursing care and what is perceived to be nursing work, the specific characteristics being mutual respect and shared planning and goal identification. However, the literature views andragogy as a term which means learner focussed rather than a broad model of education (Bhoyrub et al, 2010). Mackintosh-Franklin (2016), in her study of forty pre-registration nurse education programme HEI providers across the UK, found that nurse education remains focussed on a skills-based education, led by nurse educators who continue to concentrate on traditional acquisition of knowledge. She suggested that the reason for this is the emphasis on fitness to practice and entrance to the professional register being the end product of the nursing undergraduate programme. It is clear that there is a case for a combination of an approach which combines pedagogy with andragogy rather than an either/or in nursing. Through examining mentors' experiences of teaching clinical skills, there is the opportunity to gain more insight into how current mentors' approach this in clinical practice.

2.3.1 Situated Learning Theory

Situated Learning Theory proposes that learning is situated and normally occurs when embedded within activity, context, and culture. It is mostly unintentional rather than deliberate. Lave and Wenger (1991) considered it important that knowledge is presented in settings and situations that would normally involve that knowledge. Social interaction is essential as learners need to become involved in the 'community of practice' in order to acquire certain beliefs and behaviours essential to their learning. Communities of practice are 'groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly' (Wenger-Trayner, 2015). Lave and Wenger (1991) identified three core components required in order for a community of practice to exist. Firstly, there is the domain. To belong to the community of practice the members must be committed to the domain and a common competence that is unique to the membership as opposed to those who do not belong to the community of practice. Secondly there is the community, and this is when the members pursue their interest in the domain by interacting with each other to learn from each other through common activities and building relationships in order to share information. Lastly, there is the practice. The members of the community of practice are practitioners that share resources to help each practice within their collective domain (White, 2010). Andrew et al (2008) further expanded on the notion of a community of practice by suggesting that it is in itself a model of situational learning (i.e. that learning takes place within a situation or place) and that it is concerned with collaborative

learning between peers who focus on the acquisition of knowledge through a variety of methods. These include problem solving, discussing with others, and shadowing and observing others' practice. It is through practice placements that student nurses gain the opportunity to engage with their community of practice. It is mentors who assist and guide the student within that community of practice, although it is important to note that the literature reviewed does not consist of research studies that test this theory; rather they conceptualise the theory and its application to theory.

Yakhlef (2010) provided a potential critique of the community of practice and situated learning theory. He stated that reducing learning to participation ignores the concept of content knowledge which he argued individuals can learn without participating in its production. An example within nursing education would be anatomy and physiology as being a body of knowledge which is absolute, relatively unchanging and transferred to individuals without the requirement to participate in the clinical practice of nursing in order to learn the key concepts. However, he does state that the disparity between cognitivist and social learning schools is largely due to the fact that they are concerned with two very different facets of knowledge. Thus, whilst it is important to be aware of potential criticisms of situated learning theory, it is not to be dismissed out of hand. Indeed, it can be argued that nurse education sits across the two schools of learning and that whilst nursing students can gain knowledge in the classroom, it is in practice that they learn to apply this to the delivery of care. This is where mentors are crucial in facilitating this learning. Not only do mentors facilitate application of knowledge to practice but they also impart new theoretical knowledge to students. This is very often captured when students write academic assessments about practice and it is clear that mentors, they have worked with have shared knowledge with them.

The Community of Practice model is within situated learning theory; the learner then progresses from beginner or novice from the periphery of this community, gradually becoming more active and engaged, until they move into the centre and become an expert. This is akin to the work of Benner (1982), who applied the Dreyfus Model of Skill Acquisition to nurse education (Dreyfus and Dreyfus, 1980). The model proposed that a practitioner passes through five levels of proficiency in their journey from beginner to proficient practitioner. Pena (2010) explained that the core of this model is the progression of the practitioner from rigid adherence to a set of taught rules, through a very gradual transition to largely using intuition that relies on deep implicit knowledge. Literature supports this model as an appropriate method of clinical skills acquisition within the health professions (Carraccio et al, 2008; Daaleman, 2008). Lave and Wenger (1991) coined the term 'legitimate peripheral participation' to describe the process by which novices are

given responsibilities and tasks to perform which are peripheral but still real to the activity within an authentic environment.

2.3.2 Legitimate Peripheral Participation

Legitimate peripheral participation (LPP) includes the sponsorship of a knowledgeable practitioner to enable the novice to develop their identity as a member of that community. LPP is different from merely assigning a supervisor to a beginner in that the knowledgeable practitioner encourages the novice development through continued developmental activities leading to an increase in knowledge and skills within the community. This is the nature of practice learning within nurse education in the UK, whereby student nurses are assigned an experienced mentor (knowledgeable practitioner) to help immerse themselves in the practice learning environment (community of practice) to develop new skills.

Spouse (2001) identified that whilst situated learning theory belongs to the group of sociocultural learning theories which, in the main, concern themselves with concentrating on child development, these concepts equally apply to adult learning in practice. This is especially true of the current model of practice learning for student nurses within the UK. Student nurses have supernumerary status whilst on placement in order to maximise learning, but this also means that they must experience a broad range of experience which necessitates moving to a number of different clinical areas for an average of no more than eight weeks at a time over their course. Spouse (1998b) argued that the need for sponsorship to enable the student to integrate into the clinical area over a relatively short period of time, to facilitate learning and importantly maintain patient safety is crucial and that legitimate peripheral participation is essential for this to take place.

The origins of situated learning theory sit within the sociocultural learning theories derived from Vygotsky (1978), who believed that the heart of learning and social and cognitive learning was the social context. Vygotsky (1978) built on earlier work by Wilhelm Wundt in 1879, who identified that deterministic approaches of psychology were inadequate in being able to explain the complexity of everyday human cognition. He started a separate discipline within psychology called 'Volkpsychologie' and it is from these activity theories that sociocultural theories have evolved. Situated learning theory sits within the constructivist paradigm of learning theory which supposes that learning is an active and constructive process, and the learner is actively involved in constructing their own subjective representations of reality. New information is inextricably linked to prior knowledge.

2.3.3 Cognitive Apprenticeship

Brown et al (1989) further developed situated learning theory and emphasised the idea of Cognitive Apprenticeship. They identified that a traditional apprenticeship only allows the learners to undertake problems and tasks that arise from the demands of the workplace, as it is the job that selects the tasks that the learner undertakes. However, in a cognitive apprenticeship, it is the knowledgeable practitioner that identifies and selects the tasks that the learner undertakes and then gradually increases the complexity of these tasks. Furthermore, the cognitive apprenticeship allows for the learner to apply their skills to a wide range of contexts due to the varied practice areas the learner is exposed to (Sawyer, 2014). Collins et al (1989) outlined six main techniques involved in the cognitive apprenticeship model which are used to support learning. These are the six methods that have been identified in order to promote the development of expertise in practice, namely modelling, coaching, scaffolding, articulation, reflection, and exploration.

Modelling is when the learner observes expert performance. Within the nursing curriculum in the UK this may primarily be done in the classroom. Students may have access to clinical skills simulation areas, whereby they can watch the knowledgeable practitioner demonstrate the clinical skill, prior to trying this skill under supervision within a simulated environment. Studies have shown that this can be very useful in preparing student nurses prior to clinical placement, in particular reducing some of the anxiety students experience when faced with undertaking a clinical skill for the first time (Moule et al, 2008; Meechan et al, 2011; Chee, 2014).

Commissioned by the UK professional body, the Nursing and Midwifery Council, the United Kingdom (UK) professional body, Moule et al's (2008) study reported on one of 13 pilot sites using designated practice hours for simulation. Interviews with both students and mentors were undertaken and the findings were as reported above, with an emphasis on effective preparation and the allaying of anxiety.

Modelling is more than mere demonstration. It is important that the practitioner demonstrating the skill gives explanations and the rationale for performing the skill in a certain manner as this enables the learner to develop the cognitive processes which are important for problem solving (Wilson and Cole, 1996). Furthermore, specific to a profession with prescribed standards of behaviours (NMC, 2018d), the notion of role-modelling is vital. Studies into the role of the mentor have identified the important function of role-modelling that the knowledgeable practitioner performs (Murray and Main, 2005; Myall et al, 2008).

Coaching is when the learner attempts to perform the skill with the help and guidance of the teacher and usually follows modelling (Woolley and Jarvis, 2007). Coaching can be used to focus on specific difficulties and provide the learner with feedback to help overcome these. One of the main aims of coaching is to provide positive encouragement with a view to enabling students to achieve a learning outcome and move on to the next (Nash and Scammell, 2010).

Scaffolding describes the process by which a more knowledgeable individual assists a learner (Wood et al, 1976); it differs from coaching because coaching is concerned with the different ways that coaches foster learning, whereas scaffolding refers to the ways in which the learner is supported whilst learning (Sawyer, 2014). Scaffolding as a concept is widely written about in nursing academia and there is current literature available which examines its place in clinical learning. It is clearly advocated as a crucial element in effective clinical teaching for student nurses whilst on placement (Owen, 2009; Harrison, 2010; Valdez et al, 2012; Chambers et al, 2013).

Harrison (2010) identified key professional skills used by mentors and these include questioning, encouraging thinking aloud, debriefing and reflection. As previously mentioned, Valdez et al (2012) looked at scaffolding behaviours and carried out a study to identify these, as well as student's perceptions of this. They divided the behaviours into thought-provoking moves which consisted of questioning the students' knowledge, focus-steering moves which consisted of orientation and demonstration, as well as correcting behaviour and action-enabling moves which include instructing and guiding students as they are carrying out clinical skills. They also identified the need to withdraw the scaffold and allow students to practise the clinical skills with minimal or indirect supervision. In order to deliver effective scaffolding the teacher needs to provide clear direction, reduce any confusion about what is required and clarify the purpose of the teaching, attempt to keep the student focussed on the task, signpost effective resources and inspire the learner to increase their knowledge and understanding. Finnerty and Collington (2013) examined the audio diaries of 14 student midwives undertaking pre-registration midwifery education in the UK and found that scaffolding behaviours by mentors were similar to those identified by Valdez et al (2012). Whilst Finnerty and Collington recognised that the small sample may not be generalizable, they suggested that these behaviours were being employed by mentors across the UK.

Articulation is when the learner is encouraged to think aloud while performing specific aspects of practice. Banning (2008) suggested that articulation can be used as a prompt for the learner to verbalise their thoughts as they problem solve. Not only does it help the learner, but it also allows

the knowledgeable practitioner to identify the thought processes and clinical reasoning of the learner and either correct these or encourage further development. Questioning can also be used to help students to articulate their ideas and understanding and help lead the learner to identify the critical aspects of a concept (Kapur and Bielaczyc, 2012).

Reflection is a well utilised learning tool within the nursing profession and further explained in the work of Schön (1983). Promoting reflection and reflective practice allows for the knowledgeable practitioner to encourage the learner to critically analyse their performance and can be initiated by asking the learner how they felt the task of care episode went. Not only does this facilitate the learner to critique their own performance but it also helps the teacher to gain an insight into how the learner sees the episode and allows them to prepare to give feedback which is tailored to the learner's perceptions. In this cognitive apprenticeship model, reflection could be a brief five minute session or the teacher could suggest that the learner undertakes a more structured approach to their reflection and uses one of the many available models of reflection (for example, Gibbs 1988, Johns 2004, Driscoll, 2007). However, studies have identified that mentors rarely engage in meaningful reflection with their students, due mainly to lack of time and opportunity (Mantzoukas and Jasper, 2004; Haugan et al, 2012). In a study by Timmins et al (2013), of the 119 registered nurses who mentored student nurses, only 79 reported the ability to guide a student through a reflective model and only 84 had read a student's reflective account prior to formally assessing their practice, leading the authors to suggest that mentor preparation courses should include the importance of reflection as a learning tool. However, Bulman et al (2015), in a study of post-registration nursing students, found a high satisfaction rate with the ability to reflect on their practice with fellow colleagues. In relation to this finding, since this study involved a post-registration course there is the probability that the students were previously experienced in using reflection as a learning tool and therefore the use of reflection as a learning tool may have been well-established.

The final technique within the Cognitive Apprenticeship model is exploration. This is when the learner is encouraged to consider how their new knowledge and skills can be adapted to new situations within the practice setting (Woolley and Jarvis, 2007). According to Cope et al (2000), the knowledgeable practitioner aspires towards these activities as ultimately this is when the learner has gained the knowledge and skills to apply theory to practice. This is important as there have been many studies which have identified a 'theory-practice' gap, whereby new registered nurses are reported to have a lack of clinical skills knowledge required to perform as a registrant (Cubit and Ryan, 2011). However, the literature does not reach a consensus of opinion on this issue. For example, Hickey (2010) found that experienced nurses considered newly qualified

nurses to lack key skills, whilst Löfmark et al (2006) suggested that experienced nurses had a good ability to provide nursing care at registrant level.

Borneuf and Haigh (2010) identified the need for nurse education to integrate practical skills development, critical thinking and clinical decision making and so it would seem that exploration is a teaching method designed to address this aspect of nurse education, so long as the foundations of knowledge and clinical skills are embedded in the student's knowledge and practice. It is the ability to apply the knowledge across a wide range of clinical practice that is essential. This is especially so within contemporary nursing practice, as Felton and Royal (2015) identified that the new graduate nurse will be required to have the skills previously expected of more senior and experienced colleagues.

Collins et al (1989) also outlined that there are significant steps to delivering learning activities and these should be delivered in a certain order to allow for the learner to build on knowledge and skills. This is known as sequencing. They identified that there are three principles that need to be balanced when sequencing learning activities for students. Firstly, the learner must acquire global skills (i.e. general skills such as personal care) before local skills (i.e. tasks requiring more skill such as giving an injection) in order for them to build a conceptual map before attending to the detail of the terrain. Secondly, there is increasing complexity, which refers to the knowledgeable practitioner constructing a series of tasks that require more skills and concepts necessary for expert performance. Thirdly, there is increasing diversity which demands a wider variety of skills. This is suited to the nature of practice learning in pre-registration nursing education because no longer is there the model whereby students start their clinical practice in less acute environments and work their way up to the environment with the highest acuity. Similarly, student nurses do not attend a theory block concerned with a specific area of nursing and then experience a clinical placement in that area.

It is also important to note that the Cognitive Apprenticeship model identifies the sociology of the learning environment as being an important dimension of this framework. It has already been acknowledged that situated learning is a crucial element of the model, as well as engagement within a community of practice. However, intrinsic motivation is another vital element. This is when the knowledgeable practitioner helps facilitate a learning environment in which students undertake tasks because they are intrinsically related to an interesting or required goal. In the case of nursing, this would be the demonstration of competence within the context of assessment with the aim of passing the placement. As Meechan et al (2011) found, student nurses were more likely to actively engage with performing clinical skills whilst on practice placement if they knew

they were to be summatively assessed on these. Finally, exploiting cooperation refers to encouraging students to work together to problem solve. This is interesting with regards the UK context as within clinical practice students are paired with a mentor who is a registered nurse and the NMC does not allow student nurses to practice in the clinical area unsupervised. However, this does not preclude students from learning collaboratively within the classroom setting.

Indeed, the cognitive apprenticeship model is recognised as being employed to some degree across pre-registration student nurse and midwifery. Cope et al (2000) clearly showed, in their study of practice placement experiences of student nurses, that mentors were inadvertently using most of the features of the cognitive apprenticeship model when supervising pre-registration student nurses in practice in Scotland. Cognitive apprenticeship has also been identified as a potential learning method for medical students. Stalmeijer et al (2009) undertook a study whereby 24 Year 6 medical students in the Netherlands participated in focus groups in which they identified that most of them had encountered all six methods most associated with the cognitive apprenticeship model, thus indicating that this may be a suitable model for medical education. It is clear that situated learning theory and in particular Legitimate Peripheral Participation and Cognitive Apprenticeship are two models which are akin to the current model of pre-registration nurse education in the UK.

2.4 Experiences of learning in clinical practice

Within the present UK context, at the time of completing this research, nursing students are required to undertake at least 2,300 hours in clinical practice before they can join the Nursing and Midwifery Council's register as a registered nurse. All student nurses and midwives are supported and assessed in practice by a fellow registrant and must also experience a range of clinical settings to gain experience in their respective field of nursing before registration. As the clinical practice element of the course makes up half of their entire programme, learning in clinical practice is of considerable importance and vital in ensuring that students can demonstrate the agreed competencies required for registration. There is a plethora of research to be found in the literature on student experiences of learning in practice and this section will outline the main findings of the literature reviewed for this study. Literature and research that related specifically to mentor's experiences of working with student nurses and the role of the mentor in practice were included in this review. Furthermore, literature specifically relating to mentoring student nurses within a community setting was included.

2.4.1 Student – mentor relationship

Much of the research undertaken on the experiences of student nurses on clinical placement either focusses on or seems to have resulted in findings that weigh heavily towards the social nature of placement. Research has showed clearly that social relationships between student and mentor or student and the rest of the team are integral to deciding whether a placement area is 'good'. Levett-Jones and Lathlean (2008) found that a sense of belongingness was crucial for productive learning within the clinical learning environment. They identified that the most important influence on students' sense of belonging and ultimately their learning were the mentors they worked with. This was a large cross-national study of 362 student nurses from both the UK and Australia. Ousey (2009), through a review of a number of research studies looking at student nurse learning in practice, also suggested that the mentor is crucial in helping the learner to socialise in the environment, not merely optimising the student's sense of belonging but also learning to belong to the society and culture of the nursing profession.

This theme of belongingness and how important student nurses consider this to be for their learning whilst on clinical placement is common throughout research undertaken into student nurse learning on placement. Papp et al (2003) undertook unstructured interviews with sixteen student nurses in Finland and recognised that the student nurses felt they needed to be accepted and belong to the clinical environment before learning could occur. This was a relatively small-scale study in another European country, but these findings have been affirmed in a number of research studies since. For example, Papastavrou et al (2010), in their study of 645 student nurses in Cyprus, found that feeling part of the clinical team had a huge impact on the students' confidence levels and this in turn was crucial to facilitate learning. The response level was 90% of the entire student nurse population in the only public nursing school in Cyprus.

Nettleton and Bray (2008) ascertained that both mentors and students believed the role of the mentor to be one of pastoral care and support. This links well with mentors facilitating belongingness and the social aspect of the mentoring role. Their research study consisted of distributing questionnaires to mentors and mentees across North West England. Wisdom (2011) examined the experiences of mentors supporting pre-registration nursing students within a remote and rural island health board in Scotland. Her study was the only research set within the kind of geographical location relevant to my study that was available. She found that the personal relationship between mentor and mentee was important and likened this relationship to that of a 'nurturing family'. However, whilst this study examined the relationship between mentors and mentees specifically, it did not focus on mentors' experiences of teaching in clinical practice. My

research aims to further expand on this and provide more insight into mentor experiences within a similar community.

Sundler et al (2013) investigated student nurses' experiences of supervision in relation to the clinical learning environment. This study was undertaken in Sweden and consisted of collecting data from 185 student nurses, using questionnaires. Their findings echoed those of previous studies in so far as students showed a distinct preference for the one to one supervisory relationship with one mentor. They related these findings to Bowlby's attachment theory and explain them by suggesting that, just as in childhood relationships are crucial to learning, the availability of a responsive attachment figure is crucial to facilitating learning in a stressful environment (Bee, 2000).

This preference is echoed in much of the research into student nurses' experiences in clinical practice. Gray and Smith (2000) found that students clearly identified the qualities of an effective mentor. Students were clear about the actions of an effective mentor, which included being organised, giving regular feedback, and communicating well with the student. However, they were also able to identify the personal characteristics of an effective mentor and these were being friendly, approachable, patient and understanding, and having a good sense of humour. Much of the literature reviewed has highlighted the importance of the student - mentor relationship and how crucial this is to student learning in practice (e.g. Chow and Suen, 2001; Gidman et al, 2011; Cooper et al, 2015).

2.4.2 Mentors and clinical skills' teaching

As is clear from the above, many studies have been undertaken which examine the experiences of the student but it is evident from the literature that it is the qualities and influence of the mentor that are crucial in determining whether a student deems a placement to be of a good quality (Wilkes, 2006; Paton, 2010; Foster et al, 2015). Therefore, it is important to review the literature that looks at the concept of mentorship and what mentors do.

Andrews and Chilton (2000) undertook a study of 22 mentors and 11 student nurses over a three-month period and looked at the mentoring process as well as specifically the benefits of having a recognised teaching qualification. They asked whether mentors and students perceived any value in the mentor having an identified teaching qualification. They found that whilst mentors themselves thought this was of value, students did not rate this very highly at all. Nursing is now an all graduate profession and neither the Duffy (2003) report nor more recent reports such as the Willis Report (2012) and the Francis Report (2013) were available at the time of their

research. All of these authors highlighted the importance of the learning environment including mentors' preparation in supporting student nurses' preparedness for entry on to the register.

Borneuf and Haigh (2010) highlighted that when Project 2000 was introduced as the model of nurse education in the UK, the use of practical rooms within schools of nursing reduced, due mainly to the change in emphasis to theory. This resulted in the emphasis on clinical skills acquisition moving from being the domain of the nursing school to the responsibility of the clinical placement area. Borneuf and Haigh (2010) described in their literature review the introduction of various practice teacher roles into the clinical setting, including a study by Hilton and Pollard (2005), which evaluated the role of a clinical demonstrator within the placement. They showed that introducing this role into the placement area was beneficial to students but not in keeping with the modernisation agenda of the nursing workforce within the UK at that time. Indeed, in Scotland, such roles have not existed since Project 2000 was introduced. The responsibility of demonstrating, teaching, and facilitating the learning opportunities to carry out clinical skills lies with the mentor.

In an online survey of 937 pre-registration student nurses, O'Driscoll et al (2010) found that only 56% of these 937 stated that their mentors regularly taught them. Further findings indicated that the reasons for this included workload affecting time to teach and time spent with the mentor as well as a perceived lack of preparation of the mentor. Donaldson and Carter (2005) had previously also identified this to be an issue. They found in their small-scale study using focus groups that students reported a lack of opportunities to undertake and practice clinical skills whilst on placement. Whilst this study's findings were limited due to the small scale, they also found that students reported a lack of supervision by mentors when undertaking clinical skills. A later study by Baillie and Curzio (2009) examined first year student nurses' experiences of learning blood pressure measurement. They identified that 38% of a cohort of 447 first year undergraduate students had never been supervised when measuring blood pressure electronically and 17% when undertaking manual blood pressure measurement had never been supervised.

A study of mentors' views regarding teaching student nurses about moving and handling showed that mentors did not attempt to individualise their teaching to suit the learner's needs, nor did they encourage questioning or offer explanations to students questions when asked (Kneafsey and Haigh, 2007). This study relates to a specific skill which is usually taught by experts in the classroom. However, it does give an insight into mentors' attitudes and behaviours to a certain extent as moving and handling is a key clinical skill required and still requires facilitation of an expert to help a learner link theory taught in the classroom into practice. It is recognised that

Kneafsey and Haigh (2007) was a small-scale study, but it highlights that there is a question as to whether mentors are equipped to teach complex clinical skills in practice. This is a sentiment further echoed by Kelly (2007) in her study into student's perceptions of effective clinical teaching. Kelly (2007) asked fifteen students at the end of years 2 and 3 of a nursing programme in the USA about their experiences of clinical teaching in the practice setting and found that the students overwhelmingly reported that high quality teaching and a sound clinical knowledge was of the utmost importance to them and their learning.

Other studies have also determined there to be a lack of opportunities to undertake clinical skills by student nurses whilst on placement. Wright and Wray (2012), in their small-scale study using focus groups consisting of 21 student nurses in the child branch, found that students were not satisfied with the opportunities to learn and practice clinical skills whilst on clinical placement. They specifically highlighted the unwillingness of mentors in the community to allow them to undertake clinical skills. Stayt and Merriman (2013) also determined there to be the few chances afforded to student nurses, not only to learn and practice clinical skills but ultimately to develop the competence required for registration. Their questionnaire survey of 421 participants also found that of over half of those asked had undertaken clinical skills unsupervised without being assessed as competent beforehand.

Research has shown that student nurses are qualifying without adequate clinical skills' development. Hickey (2010) reported that several studies have found that newly qualified nurses feel ill-prepared for clinical practice. In her study of 33 student nurses in America, just over half of respondents did not feel they had received adequate individual clinical skills' teaching prior to qualifying. Similar research by Milton-Wilkey et al (2013) in Australia used an online survey to examine 530 student and graduate nurses' satisfaction with the quality of their clinical learning in preparation for registration. They reported that the majority of third year students and graduates considered themselves only partly prepared for registered practice.

One of the reasons identified in the literature for the lack of clinical skills experience is the issue of time constraints on mentors and their dual role as both mentor and practitioner. O'Callaghan and Slevin (2003) identified that mentors experienced difficulties with supervising students at the same time as caring for patients. More recent studies have also found the busy ward environment to be a significant factor which affects the learning opportunities for students. Chuan and Barnett (2012) used a questionnaire to determine student nurses', staff nurses' and nurse tutors' perceptions of the learning environment. Many of the 142 student nurses surveyed reported missing learning opportunities due to a busy ward environment, stating that often staff nurses

would undertake procedures themselves rather than allowing students to do this as they felt they would take too long. Houghton et al (2012a) also reported this in their case study research which examined student nurses' experiences of implementing clinical skills in practice.

Killam and Heerschap (2013) looked at the challenges to learning clinical skills within the clinical setting. Their study of student nurses in Canada using focus groups found that the lack of teaching experience and skills was identified as an issue. Henderson and Eaton (2013) also identified that those mentoring student nurses are not always prepared to teach clinical skills. Previous studies have determined that mentors can lack the teaching skills and knowledge required to provide effective clinical instruction to student nurses. Kelly (2007) interviewed 30 student nurses in Canada and reported that students valued not only the mentors' knowledge of clinical skills but also their knowledge of teaching. This is in direct contrast to the earlier work of Andrews and Chiltern (2000), but the plethora of literature regarding mentoring relationships and student experiences of this suggests that teaching skills and abilities of mentors are not foremost in the students' minds. Alternatively, it could be that student nurses in the UK do not value this as much as their colleagues from other parts of the world. Madhavenpraphakaran et al (2013) reported that, of the 76 mentors they surveyed in Oman, the majority felt that they required further education in effective teaching and learning styles. This is echoed in studies which have identified that mentors find their role much easier if they have had formal training in teaching (Dekker-Groen et al, 2011; O'Brien et al, 2013).

Löfmark et al (2011) used a questionnaire to determine nursing students' satisfaction with the mentoring they received in clinical practice. A total of 349 students from Norway participated in this study and it was clear that the majority of students rated mentors who were teachers higher than those who did not have these teaching skills. This supports a study undertaken in Australia by Henderson et al (2009) which also determined that there was more proactive teaching and learning opportunities provided in clinical placement areas when an experienced educator was present.

Since 2007, very few studies have been identified which relate to mentoring student nurses within a Scottish context. In particular, there seems to be little existing research which helps to determine whether the national approach to mentor preparation has made a difference. One exception to this was a study undertaken by Holland et al (2010) who looked at whether the *Fitness for Practice* curriculum model in Scotland had been successful in producing nurses for practice at the point of registration. Whilst this study was commissioned primarily to determine whether the curriculum was fit for purpose, the study also examined students' practice placement

experiences and reported that students were still finding variations in the quality of mentorship throughout their placements. This study was undertaken just after the national approach had been introduced and did not specifically focus on clinical skills teaching.

Brown et al (2012) identified that mentors were still failing to fail students with one of the reasons cited for this as feeling unprepared, despite having attended mentor preparation. However, it was unclear from that study whether the mentors had actually attended mentor preparation and whether these were the formal mentor preparation courses introduced after 2006. Veeramah (2012) undertook one of the first studies to formally evaluate the effectiveness of a mentor preparation course run by a Higher Education Institution. Their study of 346 student mentors who undertook the course between September 2007 and January 2010 reported that the majority of mentors felt that the course had adequately prepared them to become a mentor. Nevertheless, this study consisted of a postal questionnaire with questions which asked participants to rate aspects of the course and it can be argued that there are limitations to the approach used in this study. Firstly, it evaluated one course presentation delivered at one HEI, so cannot be considered to be representative of the UK as a whole. Secondly, there was no method by which participants could leave comments or additional data they deemed relevant and finally, this study was undertaken in February 2011 and it could be argued that those undertaking the course in the earlier years may have very different perceptions as they may have based their answers on how they felt in 2011 rather than the reality in 2007/2008. Whilst these studies are useful and indicate that problems still exist in the clinical learning environment, it is important to note that there is a distinct dearth of research in this area, particularly in Scotland.

Clinical teaching within the role of the mentor is largely ignored as a topic of research and the majority of studies that do look at teaching practice of mentors are in the main carried out in countries other than the UK. The few studies undertaken in the UK that refer to this aspect of the role mainly cite lack of time to undertake clinical skills teaching but do allude to mentors and students' perceptions of mentors being poorly prepared for that aspect of their role. It is interesting that in Scotland all teachers in schools need to have undertaken a substantial teaching programme before being allowed to teach young people unsupervised. Furthermore, those practising as higher and further education teachers are usually required to have undertaken formal teaching qualifications. Nurse lecturers in HEIs need to have undertaken a substantial programme of preparation to teach and teach student nurses 50% of the time, so it is worthy of note that mentors, who teach nurses the other 50% of the time, do so with a much more limited programme of preparation.

2.4.3 Practice learning in the community setting

In 2013, NHS Scotland set out its '*2020 Vision for Health and Social Care*' and, within this document, clearly outlined the vision for health care to be placed firmly at the heart of the community and with a shift towards more community care (NHS Scotland, 2013). This is a significant driver for those providing pre-registration nursing education to ensure that new graduates have experience of and some of the specific skills required to work in this area of practice. Furthermore, this would suggest that it is important that new graduates recognise the transferability of their skills across both inpatient and community-based care.

Community placements are not a new phenomenon and challenges associated with providing these for students have been identified for many years. Lloyd Jones and Akehurst (1997) found that the economic cost of providing placements was significantly more of a burden for community-based services than for providers of inpatient care. Though student nurses are supernumerary whilst in practice, they recognised that the work they undertake is valuable and eases workload for others. This is clear in an inpatient setting where students regularly undertake tasks that other staff would do, had they not been there; however, in a community setting, students are much more likely to observe (especially in the earlier stages of their education) than actively undertake care that usually another staff member would do. Kenyon and Peckover (2008) found that providing clinical placements for student nurses could be disruptive for community teams and individual mentors in particular. Staff would often rearrange their days to suit the student's learning. This could be by reducing the number of visits to patients to ensure sufficient time to discuss and reflect on care with students during the day. Mentors might also have to alter their day to avoid visiting patients who either did not wish to have students present or were vulnerable and therefore a visit with a student present was deemed inappropriate. This was found to be the case with health visitors in particular due to some of the more sensitive aspects of their role which can include child protection issues (Dixon, 1996). This inevitably could lead to tensions within teams as work was seen to be devolved to others if one staff member was mentoring a student. Literature has shown that there are limited and reducing numbers of mentors within community settings which only exacerbates the situation described above and also puts added pressure on mentors as they can feel as if they are mentoring students on a continuous basis. This, coupled with reduction of staff in community settings and an ageing staff pool, can add to mentors' workload significantly (Betony, 2012; Cooper, 2014; Ball, 2017).

Mentors have also reported disappointment with regards to the preconceived ideas of students' beliefs as to what community nursing is or is not. Students have often viewed community nursing as less challenging and complex and therefore not offering many opportunities to develop their

technical skills (Kloster et al, 2007; Murphy et al, 2012). Students perceive technical skills as being at the heart of 'real nursing' and have commented that these are more easily learned in an inpatient environment (Murphy et al, 2012). Baglin and Rugg (2010) identified that student nurses reported a lack of opportunity to suggest and try delivering different approaches to care, and found that much of their time was spent observing care delivered by the community nurse who was their mentor. There can also be a great deal of anxiety associated with commencing community placements as many students have never encountered this environment before. It has been found that due to the relative lack of portrayal of contemporary community nursing on television, film and social media as opposed to a plethora of media concerning acute care, students do not have a frame of reference to draw upon (Norman, 2015; van Lersel et al, 2016).

The literature has also identified that students can struggle with caring for patients in their own home, if the beliefs and values of the patients they are caring for challenge those of the students (Baglin and Rugg, 2010; Pritchard and Gidman, 2012; Carr et al, 2016). Pritchard and Gidman (2012) found that students can experience significant distress at the living conditions and lifestyle choices of some of the patients they visit at home. As students find it difficult to rationalise the choice of others, this can cause a substantial emotional response and add to students' stress. Furthermore, attempting to learn new skills and knowledge in an environment that is unpleasant or alien to the student (often due to factors such as smell, noise and temperature) can be difficult and frustrating and again add to heightened emotional responses from the student (Salamonson et al, 2014).

Student nurses are concerned with the development of clinical skills in practice and this is especially evident in the literature which examines clinical placements in a community setting (Merritt and Boogaerts, 2014). They often equate mastery of clinical skills with confidence and the ability to practice as a registered nurse once qualified (Baglin and Rugg, 2010). However, on the other hand, it has been reported that student nurses do identify positive aspects of placements within community settings and some do equate clinical skills with non-technical skills. For example, Peters et al (2015), in their study of student nurses who had experienced clinical placement in a community setting in Australia, concluded that students deemed their experiences to be of great value. They enjoyed working with nurses who they felt had a wide range of skills and delivered holistic care. They also reported feeling valued by the staff they worked with and that their mentors were interested in teaching. These findings were further echoed by Marshall and Shelton (2012), who, in their study of 31 students in their final year of their programme at a university in the UK, found that students reported a significant increase in their confidence, adequate mastery of skills and good support from their mentors. Indeed, Murphy et al (2012)

looked at 440 student evaluations of placements in Wales and identified that, overall, there was no clear preference for either inpatient or community placements by student nurses which is positive considering the current agenda of shifting the balance of care from inpatient hospital settings to care in community settings.

Killam and Carter's (2010) literature review examined thirteen studies of student nurses' experiences in a rural placement and identified that the challenges for students when allocated to a remote and rural area can be similar to students in other locations, for example, high travel costs, higher living expenses and finding suitable and affordable accommodation in tourist areas. Nevertheless, there are some unique considerations. The adverse weather and driving conditions were highlighted as a source of anxiety for students and this was limited to students on placements in remote and rural areas (Killam and Carter, 2010). These students also identified feelings of loneliness and isolation leading ultimately to homesickness being an issue. They found being away from friends and family and their usual support network challenging and an added stress (Killam and Carter, 2010; Webster et al, 2010; Smith et al, 2018). Lack of similar infrastructure to the urban areas where many students study can affect students' perceptions. Having access to adequate communications including internet and mobile phone signal coverage is important and has been identified in the literature (Yonge et al, 2006). However, despite the challenges that students face, they also identify many positive aspects of clinical placements in very remote rural areas.

A wide range of learning opportunities is one of the positive aspects that student often cite in the literature. Smith et al (2018) surveyed 3204 health professional students to further understand the lived experiences of students who were undertaking placements in rural areas of Australia. Students frequently mentioned the wide range of patients and conditions that they were exposed to as being very positive for their learning. They also valued working with practitioners who they view as having additional and extended skills to fulfil this role. Students were positive about the level of support they received from both their mentors and members of the wider health team (Smith et al, 2018). Students valued the fact that their mentors made efforts to ensure that they were immersed in the local community as they saw this as being valuable, not just in enhancing learning in so far as they gain a good insight into local culture and community, but also as this can help avoid loneliness and isolation that might be experienced by students whilst away from home (Webster et al, 2010).

2.4.4 Clinical skills

Literature reviewed have demonstrated widely ranging opinions as to what health professionals consider to be a clinical skill (Kurtz et al, 1998; Simpson et al, 2002; Junger et al, 2005). Different domains can be included, and these vary from practical skills, communication skills, treatment skills to diagnostic skills. Michels et al (2012) identified that clinical skills are perceived in the main to include both practical procedures, clinical skills and treatment skills and that for the health professional to undertake a clinical skill they need not only to have the knowledge of how to perform the procedure but also the underlying knowledge, understanding and clinical reasoning. Indeed, without these three components a clinical skill is merely 'a mechanical skill'. It was of interest to see in much of the nursing literature on clinical skills that these are not just seen as a psychomotor skill but also involve communication and clinical reasoning (Longworth, 2013; Mackenzie, 2015).

NHS Education for Scotland have provided a clear definition of clinical skills as being any action performed that involves direct patient care which impacts on clinical outcome in a measurable way (NHS Education for Scotland, 2007b). There has not been anything more recently published on this, and ultimately the definition is still current in clinical practice. This is important as within nursing practice there is still a lack of agreement about what is a clinical skill. These not only include technical skills such as examination skills and invasive procedures, but also non-technical skills (often referred to as 'soft skills' by nurses themselves and academics involved in nurse education), such as communication, leadership and team working, as well as cognitive skills such as decision-making and clinical reasoning. As Rennie (2009) pointed out, this implies that everything clinicians do for their patients (including actions, behaviours, and decisions) is a clinical skill.

Studies that consider students' experiences of learning clinical skills in practice often focus on task-based skills (Donaldson and Carter, 2005; Wright and Wray, 2012). Stayt and Merriman (2013) investigated students' perceptions of clinical skills' development in practice but were prescriptive in the skills they wished the students to comment upon. These were specifically monitoring blood pressure, heart rate, respiratory rate and temperature, aseptic non-touch technique, assisting with eating and drinking and assisting with comfort and hygiene. All of the skills listed are very often perceived as task based and dependent on developing psychomotor skills. Baillie and Curzio (2009) and Bland and Ousey (2012) both examined student nurses' experiences of learning and developing competence in recording blood pressures. They stated that their studies were prompted by anecdotal reporting of the perceived lack of newly registered nurses' clinical skills competence.

Baglin and Rugg (2010) found that students were focussed on mastering clinical skills and did not identify assessment as a key skill they required. This study was relatively small with only six participants; however, other literature has had similar findings. Boxer and Kluge (2000) and Henderson (2002) also identified that students' primary focus whilst out in clinical practice was on learning, practising, and developing clinical tasks.

As outlined in the literature review, there is very little research available that describes how and what mentors teach with regards to clinical skills. The research that does exist tends to focus on the barriers to effective clinical teaching, specifically teaching of a clinical nature that takes place within a clinical setting, and these are time constraints and knowledge and skills of the mentor. However, recently McSharry and Lathlean (2017) undertook a study to explore clinical teaching and learning in an acute care environment in Ireland. They identified that students were found to learn by watching their mentor and then to undertake care, which is very similar to the 'see one, do one' method of learning.

This resonates with much of the literature around 'how to' mentor as there are a number of books written in the UK that seek to instruct mentors of student nurses and midwives on how to carry out their role (e.g. Aston and Hallam, 2011; Kilgallon and Thompson, 2012; Wiggins and Heathershaw, 2013; Gopee, 2015). Indeed the 'see one, do one' method seems to be so entrenched in practice that the key principles (see Table 5 below) are identified as standing '*the test of time*' (Gopee, 2015).

Table 5: Principles of teaching a skill or competency

Principles of teaching a skill or competency
<ol style="list-style-type: none"> 1. <i>Initially demonstrate the skill in its entirety as a fully integrated set and cycle of operations.</i> The demonstration needs to be accompanied by a clear step-by-step commentary and it must be a demonstration of mastery of the skill. The correct movements that go to make up the skill must be in evidence from the outset. 2. <i>Break the skill down into its component and subordinate activities.</i> Each action must be demonstrated, explained and analysed. The relation of separate activities to one another and their integration into a hierarchy of sequences that make up the skill must be stressed. 3. <i>Skill acquisition lessons require supervised, reinforced and carefully spaced practice by students.</i> It is only by experiencing and repeating the essential movements that the learner can discover the kinaesthetic cues of successful performance.

4. *Continuous, swift, and accurate feedback must be provided for the learner.* Delayed feedback on performance makes the feedback less effective.
5. *Assess part-skills or the whole skill regularly and in work-related realistic conditions.*

Gopee (2015) adapted from Curzon and Timmons (2013)

2.5 Summary

The review of the literature identified two key themes relating to nurse education in practice. These were educational theory and how this is applied in practice, and the reported experiences of those involved in nurse education in practice. As previously mentioned, this literature review was informed by *apriori* knowledge of theory and so the literature was examined to determine the extent to which this theory was represented and found to influence current thinking on practice learning. Sociocultural learning theories feature heavily in the literature reviewed, especially those concerned with situated learning theory. The notion of the community of practice, student nurses belonging to a community and learning occurring within that community is also evident in the literature reviewed, with some small-scale research available that supports the effectiveness of this approach for student learning in practice. Within this, literature also promotes the idea of a knowledgeable practitioner 'sponsoring' their novice colleague and using various methods to support their development. Again, some research is already available which provides findings from studies that show mentors using specific skills, such as scaffolding, to do this. The literature reviewed has highlighted that whilst there is considerable emphasis on the pedagogical underpinning of nurse education, there continue to be differing views amongst the profession with regards to the correct approach in practice, specifically concerning pre-registration nurse education. This is something that the research study has attempted to address through examining mentors' experiences of teaching clinical skills in practice and the approach that professionals are employing in their practice.

The literature reviewed has also identified that, whilst much has been written about mentorship, supported by a substantial body of research, this is primarily concerned with student experience of learning in practice and how the actions of the individual mentor affects this. Literature concerned with mentor experience focusses mainly on their experiences when dealing with a struggling student and, whilst this is undoubtedly important, it does highlight a dearth of knowledge regarding mentors' experiences of teaching in clinical practice. This research study seeks to address this. Furthermore, due to the lack of literature available on mentors' experiences not just in Scotland in the UK, but in very remote rural Scotland, this research concentrates on identifying mentors experiences specific to such a geographical area. Chapter 3 now outlines the methodology, research design and methods.

Chapter 3 Methodology, research design and methods

3.1 Introduction

This chapter outlines the research paradigm and methodology, as well as the methods of data collection and analysis. This includes clarifying the research paradigm and research questions, followed by the research methodology, a discussion of the case study approach used and the associated issues. The study design is described including the data collection process. There is an examination of focus groups and a description of the research process. Data analysis is illustrated, as well as a discussion regarding ethics and practitioner research.

3.2 Research aims and research questions

The aim of this research is to explore the experiences of nurse mentors in a very remote rural area of Scotland. The enquiry focusses on those experiences relating to their teaching of clinical skills to student nurses in a type of geographical location for which very little research has been undertaken to date. Therefore, it attempts to fill a gap in the knowledge base relating both to clinical skills teaching and mentors' experiences of teaching clinical skills in very remote rural areas.

The key research questions that the research aims to answer are:

1. What are the mentors' experiences of teaching clinical skills in a very remote rural area of Scotland?
2. What do nurse mentors consider to be the clinical skills that they teach student nurses?
3. How do mentors teach these clinical skills in practice?

This is with a view to ascertaining how these findings inform current pedagogical thinking with regards to nurse education in clinical practice, as well as determining whether they are aligned with mentors' experiences as recorded in previous research studies to date or whether there are significant differences.

3.3 Methodology

This section will outline the background and rationale which has informed the study design, and how contemporary literature has been used to determine this approach.

3.3.1 Developing an epistemological stance

Epistemology is concerned with the nature of knowledge, what is considered to be valid knowledge and what it is that can be known (Ryan, 2015, p26). Epistemology is often defined as

the philosophical theory of knowledge (Powers and Knapp, 2011). It is important to examine the epistemological stance as this influences the researcher. Each individual has their own epistemology; it is inherent in every individual and it is important for the researcher to be aware of their epistemological beliefs before commencing a research project. However, the epistemological stance one takes as a researcher is just as much related to the nature of the research question and the kind of knowledge sought.

Ontology is defined as *'the image of social reality upon which a theory is based'* (Grix, 2002, p177) and it refers to the study or philosophy of being; in essence an individual's ontological position is what they believe constitutes social reality. These views, thoughts and ideas can broadly be contained within either an 'objectivism' or 'constructivism' perspective. Objectivism is the position that there are certain rudimentary types of knowledge that are always true, regardless of the individual's thoughts and wishes. Objectivism is considered to underpin positivism, which is the belief that scientific truth can only be determined by that which is observable by the human senses. However, constructivism proposes that knowledge does not simply exist to be discovered by the individual, but that knowledge is constructed from perceptions and actions of the individual within society; knowledge is therefore constructed from experience (Lewis, 2001).

3.3.2 The choice of paradigm

Houghton et al (2012a) suggested that the use of a paradigm is helpful in ensuring that research is both philosophically and ontologically congruous. The term paradigm was coined by Kuhn (1970). A paradigm is *'a set of assumptions, concepts, values and practices constituting a view of reality'* (Dyson and Norrie, 2013, p5). Essentially, a research paradigm is a way to think about and frame research (Smyth et al, 2016). Paradigms can be considered in a hierarchical manner as, in the first instance, epistemological assumptions inform the researcher's methodological considerations. This in turn affects the research design and also the data collection.

Interpretivist/constructivist approaches to research look to understand the world of human experience, suggesting that reality is socially constructed. The interpretivist/constructivist researcher relies upon the participants' views of the situation being studied. Constructivists do not generally begin with a theory but tend to develop inductively a theory or pattern of meanings throughout the research process (Mackenzie and Knipe, 2006). Interpretive approaches rely heavily on naturalistic methods of collecting data, these being interviewing, observation and analysis of existing texts. These methods ensure that there is dialogue between the researcher and the participants so that a meaningful discourse can be collaboratively constructed. The

meanings emerge from the research process itself and, in the main, qualitative research methods are used.

The aim of interpretive research is to understand an experience and find meaning in these experiences (Weaver and Olsen, 2006). The interpretivist perspective is that there is no objective reality that exists irrespective of the meanings that human beings bring to it. This is because people's understanding of reality is very different (Taylor and Thomas-Gregory, 2015). This is essentially the aim of my research, where the intention is to determine and represent those perspectives and experiences. In essence, the interpretivist paradigm recognises that the participant is the expert and that there cannot be a single correct interpretation of the reality of the concept being researched (Morse and Field, 1995).

3.4 Research design

This section will outline the research design, that of a case study approach, employed for this research. Ethical considerations and the strategies used to enhance trustworthiness are discussed in more depth, and issues relating to practitioner research are highlighted. The initial study will be outlined, as well as key findings from this and how this informed the main study that was undertaken.

3.4.1 The case study approach

Case study research has been identified as a design which is often employed within the interpretivist paradigm. As Carolan et al (2016) pointed out, both the appeal and use of case study research has grown in recent years and its attraction is often thought to be due to the holistic nature of this approach, which very much resonates with philosophical approaches within health care itself. The origins of case study research are within similar disciplines such as sociology, anthropology and philosophy, as well as education (Merriam, 1998; Simons, 2009). As Luck et al (2006) identified, one of the key aspects of the case study approach is the ability to explore, describe and possibly explain the case that is being researched with a view to developing a deep understanding and context-constituted knowledge of the events of the case.

Powers and Knapp (2011, p16) defined case study research as '*an intensive in-depth investigation of a single subject or a single unit*'. A single unit can be a small number of individuals who are deemed to be an exemplar of a larger group and, in this instance, this would be mentors of pre-registration nurses. Miles and Huberman (1994, p25) provided another definition of the case within a case study as:

'a phenomenon of some sort occurring within a bounded context. The case is, in effect, your unit of analysis. Studies may be of just one case or of several ... There is a focus, or "heart" of the study and a somewhat indeterminate boundary defines the edge of the case'.

Radley and Chamberlain (2012) identified that case study can emphasise the concepts needed to outline what is special and/or unique for the individuals involved. Therefore, the authentic voice of the participants is a crucial aspect, especially in the single case study (Hamilton and Corbett-Whittier, 2014). Indeed Stavrakı (2014) identified that single cases can provide the thick description that can prove illuminating and powerful in demonstrating what shapes an individual's experiences. They may also capture the complexities and context of the phenomenon being investigated.

Case study research allows for in-depth analysis of contemporary phenomena. Stake (1995, p237) defined a case study as *'both the process of learning about the case and the product of our learning'* and so, by definition, it is aligned with an interpretive approach as Stake's method involves attempting to understand the meaning, contexts and processes from different perspectives. This style focusses on building theory and understanding individual and shared social meanings.

Different research designs were considered prior to adopting the case study approach. Ethnography was not felt to be the best one. Ethnography is when the researcher studies a culture through immersion in that culture, observation and undertaking interviews and is typically based on anthropology and sociological traditions (Powers and Knapp, 2011). The ethnographic approach entails the researcher looking to describe a culture and gain the insider view. This research did not seek to describe a culture but to give a very specific population a voice.

Taylor and Thomas-Gregory (2015, p38) suggested that research obtained using a case study approach cannot be generalised and agreed with Merriam (1998) that the descriptive aspects of case study research produce *'an in-depth story related to a phenomenon'*. However, generalisability and producing a narrative or story are not mutually exclusive. Whilst it may be that case study research cannot be generalised in the sense of using probability theory and statistical generalisation, it can generate social science theory.

Bryman (2012) stated that case study research prompts a great deal of discussion in the literature, predominantly concerned with the external validity and generalisability. Questions often posed include concerns regarding whether data produced support the theoretical arguments generated by the researcher. In summary, the fundamental question to be posed is not whether the

research findings can be generalised and applied to a multitude of other settings but whether the researcher can actually generate a theory out of the data collected. Yin (2009) called this 'analytic generalisation'. Mitchell (1983) called this 'theoretical generalisation'.

It is clear that there are different variants of case study. There are also differing views regarding data collection, particularly whether multiple data collection methods should be used in order to aid 'triangulation'. Three of the seminal authors on case study research, namely Stake, Yin and Merriam, advocate a mixed-methods approach (Yazan, 2015). However, there is also a plethora of examples of research undertaken using single data collection methods, thus highlighting the fact that the employment of multiple methods is not an absolute requirement to produce effective and informative case study research (De Rouck and Leys, 2013; Gerrish et al, 2013; Keady et al, 2013). For this research, it was decided that only one source of data would be collected, either by focus group or interview (see Section 3.5.2). The rationale was that the research sought to gain the experiences of participants who formed part of a naturally occurring group of people; this in turn meant that it was their own understandings and perceptions that were key and, in relation to the focus groups, their reactions to the views of other professionals that they worked with. As a result, it was considered that the use of additional data collection methods was not going to provide greater insights. For example, it would have been neither appropriate, nor indeed pragmatically possible, to observe the mentors working with students in practice and this would not have further illuminated the mentors' views and how they felt about what was happening.

Simons (2009) suggested that whilst case study research is context specific there is the opportunity to apply learning to other areas. This can be achieved by constructing research questions within the study design that can ensure the data produced have the potential to make a wider contribution when analysed. Also, by analysing data and then relating them to other research, practice and policy, the researcher can proactively seek to ensure their research can contribute to a wider audience. The audience needs to be able to draw parallels in context. The aim of this research was to develop a body of knowledge relating to the specific context of mentors' experiences of clinical teaching in a specific geographical context, as well as contributing to the wider body of knowledge pertaining to mentors teaching clinical skills in practice. Adopting a case study approach in this instance has allowed for what could be perceived to be a narrow context to be examined and then allow for generalisability which is applicable to nursing education.

This research was concerned with identifying what is happening and how aspects of the mentoring journey are linked with regards to clinical teaching by mentors in practice areas; these

two aspects are clearly appropriate to investigate, using a case study approach within an in-depth qualitative study (Clarke and Reed, 2010). It was felt that this would provide a valuable way in which to explore the phenomenon of mentoring student nurses and teaching clinical skills in the specific context of a very remote rural community. Furthermore, it would provide mentors with the opportunity to give their thoughts, opinions and values to the researcher, who could then be the voice for them.

3.4.2 Ethical considerations

Ethical considerations are important when planning and undertaking research. Apart from the requirement that all research must have ethics approval before the study can be started, the researcher needs to be aware of moral and legal requirements to ensure the research undertaken is conducted in an appropriate manner. Bryman (2012) identified four ethical principles. First there should be no harm to participants, second, informed consent is required, third, there should be no invasion of privacy and finally, there should be no deception.

The Ethical Guidelines for Educational Research (BERA, 2011) make it clear that researchers must recognize the participants' right to privacy. This has been achieved by anonymising data and ensuring a secure and safe storage location. Both aspects are clearly outlined in the participant information sheet (see Appendix 1). Anonymity of data is important and, in this study, especially, due to the very small teams involved in the research. In order to ensure this, mentors are not referred to using pseudonyms or initials but just as 'a mentor' or 'a number of mentors'. This, by necessity, was carried through into the presentation of the findings, where the views of mentors, as expressed in the focus groups, were used to exemplify the range of perspectives discussed. Ensuring anonymity of location is equally important as if the location were to be described, even though not named, it could be possible to identify the mentors who had participated in the study. It may not be achievable to maintain NHS Board area anonymity since the name of the researcher is evident. However, the Board area is not named in an effort to minimise the risk associated with this.

Walford (2005) has argued that, with small scale case study research, there is always going to be the chance that participants can be identified, and therefore absolute anonymity is not possible. Kushner (2000) went further and questioned anonymisation, arguing that this denies the participants an identity. As Simons (2009) stated, she anonymised for a number of reasons, which included protection of individuals in the event of adverse reactions or consequences of research findings, and publication based predominantly on the potential of unfair judgement of others. She

also highlighted that authors and publishers may insist on anonymisation, due to litigation and legal concerns.

Informed and valid consent is also imperative, and this is achieved through the use of an information sheet and consent form that participants sign before participating. (See Appendix 2 for a copy of the consent form given to participants). I allowed a period of time between giving the participant the information sheet and collecting the consent form to enable a period of reflection and thought by the participant. This can be useful in allowing participants to think carefully about their decision and read and reread the information provided. The participants need to be aware of their rights with regards to withdrawal from the study and this must be explicit in the information sheet. Whilst incentives are permitted, these must be appropriate and must be disclosed by the researcher when reporting their research design and findings. In this research study no incentives were offered.

3.4.3 Issues related to practitioner research

Research relationships are discussed widely in the literature and any relationships which raise questions regarding access, harm, power, secrecy, confidentiality, and deception need to be considered and ultimately resolved (Burgess, 1989). This is an important factor that has been considered in this research study, due to the fact that the researcher is, in effect, an insider researcher i.e. someone who belongs in the group in which they are researching (Breen, 2007). There are undoubtedly advantages to being an insider researcher, such as having a good understanding of the culture which is being studied and having established relationships which can help judge the credibility of the information received (Bonner and Tolhurst, 2002). As Smyth and Holian (2008) identified, being an insider researcher can also allow for a good knowledge of the politics of an organisation and a real understanding of how it works. This enables the researcher to know how best to recruit participants but also to have a good knowledge of the background to the case being studied. In this research, being an insider researcher allowed me to be familiar with the structure of the teams, where they were located and the numbers in each team. Whilst recruitment to this study was initially opened to all mentors across the NHS Board area, in the end the data collected were limited to a certain geographical area within an area of practice. This was because, by keeping research to a specific geographical location, it produced insights which related to mentoring student nurses in community settings and those student nurses who were experiencing clinical practice in an area at a significant distance from their HEI campus. These are findings that may not otherwise have been discovered and this focus bridged a gap in previous research, as identified through the literature review. Furthermore, being an insider researcher also allowed access to email contact of all mentors to recruit to the research.

However, there are potential disadvantages to this role. One of the main issues identified in literature is the possibility of a pre-existing familiarity leading to a bias and loss of objectivity (DeLyser, 2001; Hewitt-Taylor, 2002). This, coupled with the possibility of a role duality occurring and these roles being at odds with others, could affect the balance of the research and data collected (Gerrish, 1997). These advantages and challenges were kept in mind whilst the research was being planned and during the research process itself.

3.4.4 The initial study

An initial study to test the method prior to the main study was carried out within an NHS Board area, consisting of three individual interviews. Participants were recruited via email advert. Questions were developed with the aim of producing rich data. These included questions such as 'what are the positive aspects of being a mentor', 'what do you teach student nurses on clinical placement?' and 'what methods do you use to teach student nurses? The initial plan was also to undertake a focus group as well, but it proved impossible to recruit sufficient participants who could attend at the same time and in the same physical location.

These initial three interviews produced valuable data, but it became clear that there were some changes and additions that were needed to the main study in order to ensure that more data were produced regarding the experiences of participants. It was important that the questions relating to mentor demographics remained. Questions which ascertained how long a nurse had been a mentor, their clinical area and whether they had undertaken a formal mentor preparation course were deemed key, in order to seek information that was specific to the NMC Standards for Mentorship which place great emphasis on these factors. The NMC Standards for Learning and Supervision in Practice (NMC, 2008) were introduced to ensure there is parity of quality supervision of nursing and midwifery learners in clinical practice. The standards include very strict parameters that nurses, and midwives must demonstrate in order to support learners in practice. It was also thought that these might be useful introductory questions to help 'warm up' the focus group participants.

It became clear that by changing the type of questions, this would help mentors focus on teaching clinical skills rather than discussing the concept of mentoring in general. In addition, the wording of one of the questions about teaching clinical skills may not have allowed for a full answer. This question was changed to elicit how mentors teach student nurses in the clinical area. It was noticed that when mentors were asked 'what methods do you use to teach student nurses in the clinical area?' this needed clarification as the question was not clear to them. The question about challenges to being a mentor, first asked in the initial study, was retained, in order to further

examine the question of lone working or rural working affecting mentors' experiences of teaching clinical skills. The final question in the initial study was 'are there any aspects of being a mentor that you would like to talk about specifically?' Each interviewee said 'no', so it was clear the use of a yes/no question may not be helpful and needed to be amended.

Following the initial study, I recognised the need to develop the type of questioning and especially probing to gain richer data. This was because the data collected in the initial study did not provide the depth of data expected. The participants had answered some of the questions with 'yes' or 'no' answers and so the anecdotal and descriptive data expected were not forthcoming. On reflection I had been naïve in my expectation that the participants would automatically regale tales and anecdotes to illustrate their experiences and it was at this time that it was realised that the main study design required more thought and consideration.

The desirability of using a 'tour' question to gain data about a mentor's experiences was also discovered in the initial study. Rubin and Rubin (2005) described a 'tour' question as one in which the interviewer is suggesting to the interviewee that they act as guides in identifying the key points which they deem important. This was then instituted for the main study and proved beneficial in gaining an insight into mentors' experiences of teaching a clinical skill which had particularly resonated with them, thus allowing for a deeper exploration of their experiences. This was followed by specific probing questions, such as 'was this typical?' to elicit more detail.

The literature advocates the use of interviews as a suitable method to collect qualitative data (Lambert and Loiselle, 2008; Doody and Noonan, 2013). Whilst the initial study did produce some data of interest, the method of collection was not ideal. There were a number of practical difficulties associated with recruiting participants and the time of year meant that it was not possible to interview mentors across the area planned as travel was cancelled due to inclement weather. Furthermore, the small sample size this produced meant that the data collected were informative but did not provide the personal insight and experience that was sought.

Alvesson (2003) suggested that interviewees will behave in a certain way which they consider to be socially acceptable in an interview and that they may give the expected answers and opinions which are considered to be the majority views within that community. Guest et al (2017) found that personal and sensitive issues were more likely to be disclosed within a focus group rather than during an individual interview. This was from their randomised study of 15 previous studies comparing these two data collection methods. Coenen et al (2012) concluded that focus groups allowed for more concepts to be identified and highlighted which may have been due to the more

relaxed and supportive atmosphere of the focus groups as opposed to an individual interview. Having reviewed these findings, I considered that undertaking focus groups in order to collect data for the main study would be a more suitable method and thus I decided to use focus groups as the primary method of data collection. However, I was aware of the need to keep the individual interview as an alternative option for any participants who wished this.

3.5 The main study

This section outlines how participants were recruited for this study. Data collection and data analysis methods are discussed, as well as issues relating to practitioner research, that is research which is undertaken in the clinical setting which builds on practitioner knowledge (McCormack, 2003).

3.5.1 Sampling and recruitment

Focus groups were used to collect the data for the main study, for the reasons already given. However, the option was retained of an individual interview for mentors who would rather have a one-to-one interaction than participating in a group. I was mindful at that stage that recruitment could be an issue and wanted to ensure maximum participation. In the end no one asked for this option.

Initial 'access' to the organisation was acquired through local NHS Research and Development approval. However, recruitment of groups of participants was more problematic. Notwithstanding the need to get groups of nurses from the same teams, all of whom were mentors and able to come out of their clinical area for a period of time together, there was the added issue of persuading potential participants of the benefits of contributing to this research. At the beginning of the research I had not considered whether the focus groups needed to consist of mentors from the same team or clinical area. However, in my role within practice education, I concluded that teams of mentors found mentor development activities such as mentor updates more productive and valuable when interacting with mentors within their own teams. Therefore, in line with this, it seemed desirable to follow the same pattern for the focus groups.

The information sheet needed to be instructive, eye catching and look professional (see Appendix 1). I had indicated on my initial ethics application that I would contact mentors by email. I felt this was important so as to avoid the insider effect, with mentors feeling obliged to participate due to my role at the time of recruitment to the study. At that point, I was employed by the NHS Board in a role that entailed supporting mentors in carrying out their role. This included delivering mentor updates, auditing practice placement areas, and helping mentors to work with failing students.

Pictures were used in the information sheet in order to attract mentors' attention. The estimated numbers of mentors who would be eligible for the study would be 200. However, geographical spread is approximately seven hours across the area. This also includes ferry journeys which do not enable 24-hour travel across the area. The extensive geographical area in which potential study participants resided meant that it would not be realistic to expect large recruitment numbers.

As with the initial study the response rate was low to start with, having only had replies from mentors from three community teams. The plan was to recruit participants from all settings (including hospital). Furthermore, two of the teams were at a considerable distance which meant arranging travel and accommodation to undertake these groups. The time of year that was available for the data collection was also an issue as these were to take place in the autumn. It was important to ensure that all participants were able to take part, and this could change, due to patient workload, the will of senior colleagues and the fact that the weather affected ferries.

Matukaitis Broyles et al (2011) identified that time and work constraints, lack of interest in the research topic and ambivalence towards the perceived value and applicability of the research to their own practice were the key factors which hinder the recruitment of health care professionals to take part in research projects. However, they did find that if researchers communicated well with prospective participants as well as building a good rapport with them, nurses and other health care professionals were more likely to agree or volunteer to participate in research studies. They also identified that the support of the employer was key. This reflects my approach to recruitment. The support of the employer had been secured and I already had a rapport and professional relationship with prospective participants.

Luck et al (2017) supported the work of Matukaitis Broyles et al (2011). They identified also that the personal touch can improve recruitment but there are potential ethical issues in the direct approach. Bradbury-Jones and Alcock (2011) agreed with this, suggesting that the effects of having a personal relationship with potential research participants may break ethical boundaries. Therefore, I was very careful to ensure that recruitment was as outlined above and that none of the mentors who were eligible as participants felt coerced into taking part in the study. Archbold (1986) stated that studies have found no difference in response rates when participants were recruited through an intermediary or the researcher themselves. Badger and Werrett (2005) suggested that there may be coercion, regardless of the status of the researcher, and that in most cases the personal touch yielded higher response rates no matter who was actively recruiting.

Considering the points made above, I would argue that the recruitment strategy employed for this study was ethically sound as well as appropriate for this research.

During my initial study it had not been possible to interview mentors in these areas due to issues with travel disruption due to weather. This location of participants for the main study provided the added advantage that they were from a geographically different area to the one adopted for the initial study, but nevertheless fulfilled the same criteria of being remote and rural. These teams were all located in areas at a distance from a main university campus and also represented three of the four fields of nursing.

The first focus group consisted of five staff nurses who represented five out of the six mentors in that community team. One of these mentors chose to attend even though they were on maternity leave at the time, which showed a genuine interest in mentoring and desire to tell her story. The second focus group consisted of three mentors – all staff nurses - and only one mentor in that team could not attend. The third and final group consisted of three mentors and they represented all of the mentors within that team. The teams consisted of mentors across three of the different fields of nursing (adult, mental health and learning disability), near complete teams of mentors, as well as nurses who worked predominantly in community but also within a small community hospital. Thus, recruitment to the main study provided maximum variation in order to gain a wide variety of perspectives.

The recruitment pattern for the main study was positive as in my initial study I had problems with recruitment; this time mentors showed a great willingness to participate. There are a number of possible reasons for this including the time that had lapsed between the two studies, there were different staff in post, and the fact that the mentors were from areas where no one had taken part in the initial study. In addition, care was taken to improve the information sheet following the initial study version, and also it is possible that the use of focus groups may have encouraged staff who worked in existing teams to take part.

The focus groups were undertaken in work settings as this was identified by the participants as the most suitable setting and the one with which they were comfortable. This meant that they were familiar with their surroundings, able to access refreshments and they were all at locations that the participants were used to seeing me from my other role. The staff were either in uniform or in other clothes, depending on whether they had come in for the focus group on their day off. I did not wear a uniform in my substantive role but deliberately chose on this occasion to wear a more casual outfit. This appeared to add to participants' ease and promoted a conducive

atmosphere which again enhanced the mentors' participation and the quality of data ultimately collected. This concurs with the work of Damon et al (2013) who undertook an experiment with 67 students from California State University. In this experiment students were randomly assigned to follow directions from a researcher undertaking an experiment who was either dressed professionally or in casual dress. They had initially predicted that students would follow the instructions of the professionally dressed person more accurately. However, this was not the case and students were more compliant with the instructions of the casually dressed researcher. Damon et al (2013) suggested that the reasons for this could be that casual dress can signify similarity and thus reduce any perceived power imbalance. Also, professional dress can exacerbate an anxiety and create a perception in status differences between two individuals. Finally, they concluded that if a researcher is dressed professionally, this may cause a stronger participation reaction bias and so participants (in this case students) may be inclined to rebel against a professional, reacting to potential power imbalances. Although this study was with students, this may also apply to colleagues as within nursing there can be a perceived hierarchy and so this is just as applicable.

3.5.2 Method of data collection

Focus groups concentrate on the interaction between participants which is facilitated by the researcher. A focus group looks to produce discussion which can be prompted by clearly formulated questions. Focus groups are different from group interviews as in group interviews all participants are asked the same questions in turn whereas in a focus group the researcher poses questions to facilitate group dialogue. Good practice points for focus groups include ensuring an appropriate number of participants so that the conversation flows between participants (Freeman, 2006). The facilitator (whether this be the main researcher or someone else brought into the group especially) should have the appropriate skills to focus discussion and promote participation by all. Both group leadership skills and good communication skills have been identified as essential for facilitators of focus groups (Greenwood and Parsons, 2000). Shaha et al (2011) suggested that groups may be susceptible to moving 'off topic' and start talking about issues out with the main topic area and this is when good communication skills and especially skills at bringing members back 'on topic' are essential.

Kitzinger (1994) favoured the use of pre-existing groups, as she saw this as an invaluable way of investigating how groups, where the members are familiar with each other, discuss a topic together. Brown (2015) found in her study using focus groups in naturally occurring settings that the insights gleaned from her research would not have been available from groups of strangers or people who did not know each other well. Hollander (2004) also argued that there is the danger

of a degree of artificiality happening in focus groups formed by the researcher, whereas this is rarely seen in naturally forming focus groups. This supports the approach taken in my research.

The mean number of participants per focus group was three and this was representative of the small teams in which these mentors worked. All of the groups included the majority of mentors who would naturally work together in these settings. Some authors advocate an ideal number for a focus group. For example, Doody et al (2013) deemed that for a focus group to be effective they should constitute at least four participants. However, this is not a uniform opinion, with Morgan (1997) reporting a successful focus group with three highly involved participants and suggesting that the constraints of the field and the purpose of the research must be taken into consideration. As Brown (2015) found in her study using focus groups in natural settings, having focus groups that consisted of people who knew each other worked well. She found that bringing people together in a location where they would naturally meet allowed for any artificiality to be removed and facilitated a more relaxed group that is more likely to disclose personal thoughts and insights.

Interaction between the members of the focus group is said to be at the crux of the focus group method of data collection but the actual minutiae of this is rarely reported (Webb and Kevern, 2008; Belzile and Öberg, 2012). Focus group participants are '*social beings co-constructing meaning while in the focus group*' rather than participants who all share a common view (Belzile and Öberg, 2012, p459). Markova et al (2007) suggested that there are three levels of dialogue which are important to bear in mind. Firstly, the interaction between the focus group participants can help the members make sense of concepts and ideas and also sense-check these. Secondly, there is interaction between the participants' thoughts, their ideas and traditions of the group membership. Finally, the third level of interaction within the focus group is the interaction with how and what is traditionally said about key concepts and ideas. This is important and the approach that was undertaken for this study.

If the focus group is concerned with the interaction between participants as much as the discussion itself then it is necessary to pick up relevant non-verbal communication. Shaha et al (2011) suggested a log of speakers' changes is essential to aid with transcription and also advocated that detailed field notes can enhance analysis. This can be done by the researcher /facilitator making notes. This was very much the case for me when undertaking the three focus groups.

The focus group recordings were digitally recorded. Transcriptions were stored on a pen stick that was encrypted and stored in a locked drawer in a locked office to ensure security. The digital

recording device was also stored in a locked drawer in a locked office. The intention is that all data will be destroyed according to University policy.

3.5.3 Data analysis

Data analysis was undertaken as soon as possible after the focus groups took place. It is recognised that a systematic approach to analysing data within qualitative research is important. For example, Lincoln and Guba (1989) suggested that following a framework provides clear evidence of the process of data analysis which can then increase the level of authenticity, as well as showing the data analysis to be consistent throughout. Marshall and Rossman (2016) identified that a typical analytical procedure consists of several phases which include data organisation, immersion in the data, generation of potential categories and themes, coding the data, offering interpretations, looking for alternative understandings and then finally report writing. Coding is based on looking for recurrent instances within the data collected. Bazeley (2014) recognised that coding data is not only a labelling process, but it is also an aid to stimulating and facilitating analysis. It is not a one-off process but can take place repeatedly in an attempt to extract themes and perspectives and give rise ultimately to rich data. Coding is used to interrogate the data, create ideas and thus draw meaning from the data.

Also, of importance are the decisions about how the analysis of group data is handled, for example, those data generated by focus groups as opposed to individual interviews. Of relevance here is the recommendation of Spencer et al (2014) who identified two principle methods for analysing group data such as that produced through the use of focus groups. These constitute either a whole group analysis or a participant-based analysis approach. In the former, the data from the entire group are merged and individual contributions are not defined. In this research, a participant-based group approach was chosen in which each participant's individual contribution was analysed within the context of the discussion itself. This fits with the interpretivist paradigm as it allows for each individual to create knowledge and for them to be recognised as the 'expert' regarding their own experiences, but still within the context of the group. After consideration of different approaches regarding the phases of analysis, the process adopted for this research was based on an adaptation of the framework proposed by Braun and Clarke (2006), as shown in Table 6.

Table 6: Phases of thematic analysis

Phases of thematic analysis
Phase 1. Familiarising yourself with your data: Transcribing data, reading and re-reading the entire data set, noting down initial ideas
Phase 2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
Phase 3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme
Phase 4. Reviewing themes: Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic “map” of the analysis
Phase 5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme
Phase 6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis
(Adapted from Braun, V and Clarke, V. (2006))

The overall aim of the familiarisation stage is to allow the researcher to fully immerse themselves in the data (Rabiee, 2004). Whilst some researchers may use a transcription service, undertaking this personally assists with immersion in the data. This is a view shared by others who advocate that personal transcription is essential, especially for novice researchers (Gale et al, 2013). Thus, each focus group was transcribed by myself and within 24 hours of it taking place. This allowed me to remember not just the words spoken but also the non-verbal language, some of which was unusual and memorable. Latent content including nonverbal communication is as important as the words spoken as not all focus group participants can adequately verbalise their thoughts and feelings (Carey, 2016). Tecau and Tescasiu (2015) also referred to the importance of examining non-verbal communication, in particular gestures and posture. Through listening a few times to the recordings, I was able to look at the notes made with regards to the body language and non-verbal communication that I had observed during the focus group, and add these into the margins

of the transcripts. This also allowed me to see a pattern of non-verbal behaviour which added to the coding.

After this familiarisation stage the data were coded, which entailed highlighting interesting segments of text and noting in the margin a description of this segment. This was kept as short as possible, with long sentences being avoided. This enabled further annotation of notes and ideas in the other margin which allowed for further development of ideas or questions to be explored later. See Table 7 which includes an excerpt of this process:

Table 7: Coding labels and examples

Coding labels	Focus Group 3 excerpt ...	Notes and Ideas
Professional development	M1: I often finds it makes me question my practice so it makes me go off and learn stuff, so I am able to pass that on - so it's about my learning as well as the students	Learning from each other, maintaining professional practice and knowledge
Professional development	M2: I would say I learn a lot from the students as well. They can bring a lot to the team	Learning from each other, welcoming to team, and excitement of new colleague?
Positive	M3: It was nice to see that my student really enjoyed her time here. It was encouraging for me to look forward to having students in the future	Positive feedback for mentor - wanting to work with more students
Negative	M2: You can spend most of the day in the car with a student and you don't have a choice about it	Lone workers - different view of having students

When identifying themes from codes some researchers may choose to decide on codes *a priori* or they identify these as the transcripts are written and analysed. This research was concerned with eliciting mentors' experiences and as the literature review had already identified a lack of knowledge pertaining to this, it was neither appropriate nor possible to identify codes in advance. In order to capture a true picture of individual perceptions it as important to start this analysis with as few preconceptions as possible.

The data and similar codes were clustered under headings in order to identify the developing themes (see Table 8). Codes are used as labels to give a symbolic meaning to the information gathered in a study and are an important part of the analysis process. As Miles et al (2014)

identified, coding is a reflective process which allows for the beginning of deep analysis and interpretation, rather than this merely being a technical process. The coding terms were descriptive in so far as they were used to provide a label to summarise the essence of the data. Process coding was also used to identify conceptual actions described from the participant data relating to mentor actions. Values coding was used to identify personal values and beliefs as expressed by study participants. The coding approach was inductive, and the final codes derived are outlined in Table 8 below.

Table 8: Identification of themes and codes

	Identification of themes and codes
Theme 1	Clinical skills teaching
	Clinical skills taught (sub codes: task, procedure, other)
	Methods of teaching clinical skills (sub codes: demonstration, questioning, explaining, discussion)
Theme 2	Role of the mentor
	Facilitation of learning
	Pastoral care
	Professional development
Theme 3	Geography – very remote rural Scotland
	Working in a rural community
	Weather and associated issues
	Culture and society
Theme 4	Values
	Positive
	Negative

In addition to the use of coding to analyse the data, I also used jotting to aid iterative analysis of the data produced. Jotting is usually defined as writing brief and spontaneous handwritten notes. This also helped with the reflexivity of this research by supporting a cycle of reflection throughout this part of the process. Jotting is in addition to handwritten notes mentioned previously about my recollections of body language and non-verbal behaviours occurring during the focus group. The jottings I included were concerned with my personal reactions to what the participants were saying and questions regarding the data being produced that merited further thought and investigation. Cross referencing to similar data produced in another focus group was important and the use of jottings helped with this, as well as the use of coding and the reflection on and revision of codes.

3.6 Strategies to enhance trustworthiness

Trustworthiness in reference to qualitative research is concerned with establishing credibility, transferability and dependability and is important when ensuring rigour within this study (Lincoln and Guba, 1989). In order to gain credibility (how believable the data are) it is necessary to demonstrate both reliability and validity. Hammersley (1992, p.67) defined reliability as *‘the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions*. Moisander and Valtonen (2006) argued that for qualitative research it is necessary to ensure that not only is the research process transparent and sufficiently detailed but also that the theoretical concepts both in the rationale for the research and in the subsequent findings are visible.

As suggested by Lincoln and Guba (1985), the rigour of qualitative case study research can be assessed using the criteria of credibility, dependability, conformability, and transferability. Nevertheless, data validation is often associated with reliability and validity and the three principle proponents of case study methodology (Stake, 1995; Merriam, 1998; Yin, 2009) have differing views on this (Yazan, 2015). Yin (2009) held a traditional view that in order for research to be deemed to be of quality, validity and reliability must be evidenced to demonstrate rigour. On the other hand, Stake (2004) and Merriam (1998) considered there to be a number of different perspectives or views within each case that could be represented and therefore methods such as member checking would be sufficient. Member checking is when participants are invited to provide informal and formal validation of the data collected. It is important to note that this is not a method of validating accuracy of the analysis and interpretation but can be a good way of gaining feedback as to the probability of the researcher’s interpretation (Powers and Knapp, 2011). In this study, participants were invited to read the findings, but none asked to do this. It is perhaps the case that within small focus groups this may not be helpful as the analysis of the data is iterative and relies not just on the spoken word but also on non-verbal behaviours.

This research is bounded with the interpretivist paradigm and therefore it is useful to consider criteria specifically relevant to this approach. Angen (2000) suggested criteria for evaluating interpretivist research and these included carefully considering the research question, as well as ensuring that it is articulated well and undertaken in a respectful manner. The research should evidence clearly how choices and interpretations were made during the research process and that written accounts should include well written and persuasive arguments. Angen (2000) also considered the ethical validity, which is the recognition that the choices made by the researcher during the process may have political and ethical consideration. Political considerations are those that may affect exiting policy, either through validation of existing processes or through

criticism of these. Therefore, it is important for the researcher to consider whether the research is helpful to the population it concerns. The researcher should also seek out and consider alternative explanations to the ones they have deduced, as well as asking a central tenet of all research which is 'have we learned something from this work?' Substantive validity is another consideration of Angen (2000). This is when the researcher evaluates the substance of their interpretive work. In order to demonstrate this, it is important to see the evidence on which the researcher's interpretative choices are made. This will help assess any biases that are inherent during the research project. Finally, the use of self-reflection or reflexivity can help address these.

Reflexivity is an approach that has been utilised throughout the research journey. Reflexivity is a continual process of reflecting on one's own thoughts, in particular reflecting on personal biases, preconceived notions, assumptions and theoretical and ideological predispositions and commitments (Powers and Knapp, 2011). This is important as any research involving immersion in a social world (particularly one very familiar to the researcher) has the potential to be influenced by the researcher's construction of meaning, as well as the researcher's behaviour having the potential to affect how participants respond (O'Reilly and Kiyimba, 2015). I not only undertook personal reflection but also used peer reflection and discussion with a fellow PhD student. This informal peer support was invaluable in providing me with the opportunity to discuss findings and ideas and my colleague helped aid my reflexivity by questioning my deliberations and analysis.

Initially I had considered the use 'member checking' as a strategy to enhance credibility. However, it can be argued that the very nature of the focus groups is to use group dynamics to produce data and if the group membership or circumstances were to change the perceptions regarding the data may be very different. In effect this would produce a 'second' order of data, rather than 'checking' the initial validity of the data as collected by the researcher. Whilst participants were indeed offered the opportunity to see the study findings, in reality none of them requested to do so. Working through the research process highlighted how member checking was not seen as appropriate for a study of this size in this specific type of geographical location.

Dependability can be evidenced when there is clear reporting of the decision-making processes undertaken throughout the research study. Shenton (2004) suggested that this can be evidenced through clear and thorough reporting of the research process, including providing detailed explanation of operational data collection processes and rationale, as well as appraisal of the findings using a reflexive approach.

Merriam (1998) stated that transferability is the extent to which research findings can be applied to other similar situations. In the specific instance of a case study approach it may be that each case is deemed to be unique. However, Stake (1995) and Denscombe (1998) proposed that whilst each case may be unique, they will also be example cases of a wider group and therefore there is always the possibility of transferability and theoretical generalisation. Through the researcher providing sufficient context and background information, this will allow readers to apply findings to other cases and enable that transferability.

Thick description (a term coined initially by Geertz, 1973) has also been identified as a strategy to aid rigour (Koch, 1994; Stake, 1995; Popay et al, 1998). Thick description is when the researcher ensures that the research is described in sufficient detail for judgements to be made by others external to the research. This aids transferability. Thick description consists of not only a clear account of research methods and the context but also examples of raw data which could include quotations and/or field notes. Thick description is often used in case study research and deemed useful in aiding rigour (Houghton et al, 2012b). Through ensuring sufficient information to allow for context and background of this research to be clear and providing thick description transferability is promoted.

3.7 Summary

This chapter has presented the methodology of this study. A clear rationale for the approach and data collection methods used has been provided, as well as an account of how data have been analysed using thematic analysis. Methodological issues including a critique of contemporary literature have been examined in some depth. Ethical issues have also been presented and discussed. The design of this research is a case study approach using thematic analysis as a method to analyse data.

The findings of this analysis are presented in the following chapter where it will become clear that the data collection methods have proved appropriate in obtaining data relevant to the key research questions. The aim of the focus groups was to gain an insight into mentors' experiences of teaching clinical skills in a very remote and rural area of Scotland, determine what mentors consider to be clinical skills and how they teach these to students they are mentoring in clinical practice.

The themes identified have not only highlighted expected aspects such as facilitating learning and identifying learning objectives but also unanticipated aspects such as the considerable impact of geography and culture which will be discussed in the following chapter.

Chapter 4 Findings

4.1 Introduction

As outlined previously the aim of this research was to explore the experiences of nurse mentors in a very remote rural area of Scotland. The enquiry focussed on those experiences relating to their teaching of clinical skills to student nurses in a type of geographical location for which very little research has been undertaken.

The key research questions that the research aims to answer are:

1. What are the mentors' experiences of teaching clinical skills in a very remote rural area of Scotland?
2. What do nurse mentors consider to be the clinical skills that they teach student nurses?
3. How do mentors teach these clinical skills in practice?

These findings are presented under three main theme headings: Clinical Skills Teaching, Role of the Mentor, and Geography – Very Remote Rural Scotland. A fourth aspect, apparent in the data, was that of the values and attitudes of mentors. However, rather than form a separate fourth theme, these insights have been embedded throughout the findings of the three main themes.

4.2 Clinical skills' teaching

Mentors were prompted to identify what clinical skills they taught student nurses whilst they were in their clinical area and how they taught them to perform these skills, and the subsequent discussion identified the positive aspects and challenges that these mentors faced. This section outlines these findings including what mentors term 'clinical skills', which clinical skills mentors deem to be important for student nurses to master and the skills that they find student nurses are most concerned about learning. This section also summarises the methods that mentors identified they used when teaching clinical skills to student nurses in practice.

4.2.1 Clinical skills

The clinical skills identified by the mentors are listed in Table 9. These have been grouped according to professional aspects of care, clinical care, and psychomotor skills.

Table 9: Clinical skills identified

Clinical skills identified by mentors in the three focus groups
<u>Professional aspects of care</u>
How to be a guest in other people's homes
Assessing the patient holistically (not just focusing on the physical health problem)
The importance of maintaining confidentiality
<u>Clinical care</u>
Assisting with washing and dressing
Ensuring oral hygiene
Assisting with eating and drinking
Ensuring adequate nutrition and hydration
Assisting with elimination and bowel health
Promoting continence
Recognising the acutely unwell patient and initiating appropriate care
Resuscitation and follow up care in an area without intensive care and ventilator support
Accurate documentation of patient care
Last offices following the death of a patient
Communicating well with the patient and relatives
<u>Psychomotor skills</u>
Administering medications
Taking blood cultures
Inserting an IV cannula
Taking blood samples (venipuncture)
Taking urine samples
Inserting a catheter
Moving and handling patients both in the ward and in their own homes
Dressing wounds
Doing patient observations (taking a patient's blood pressure, temperature, and pulse)

Whilst six of the mentors identified specific skills e.g., venepuncture, nine of the participants talked about care in general such as 'general patient care' or 'nursing skills'. The mentors in this study did not suggest that this was an exhaustive list, but these were the specific terms they used. It is clear from the list in Table 8, as well as from much of the discussion within the focus groups,

that these mentors do not consider a clinical skill to be one that is purely made up of a psychomotor activity e.g., taking a patient's blood pressure.

Many of the mentors mentioned the skill of being a guest in someone's home as important and as all the mentors in the focus groups were involved in visiting and caring for people in their own home, this was to be expected. However, what was surprising was that it was very often the first skill mentioned, and great emphasis was placed on it. The mentors identified that caring for someone in their own home was very different from caring for someone within a hospital, hospice, or care home and that this required different knowledge and skills. The mentors were very aware of the potential challenges for students commencing community placements, particularly with regards to the different approaches and skills required when caring for a person in an environment over which the patient has the control and the nurse is the guest. The mentors talked about how they were proactively managing this aspect of student learning. The mentors also voiced their concerns that it was crucial that any member of the team visiting patients in their home must be aware that they are a guest in that person's environment and must act as such. As one explained:

'I always talk to them [students] about how we are going into someone else's house and it is important to be respectful They need to be careful with their body language'.

Another clinical skill which the participants deemed to be of great importance was 'essential' or 'basic nursing care', by which they meant caring for the individual's personal hygiene, assisting with dressing, ensuring good nutrition and hydration and helping to mobilise. One described this as '*activities of daily living as being at the crux of [their] job*'.

The mentors were clear that for them the essentials of nursing care consisted of assisting patients with the activities of daily living which entails maintaining a safe environment, communication, breathing, eating and drinking, elimination, washing and dressing, controlling temperature, mobilization, working and playing, sleeping, sexuality and death. This concern with the essentials of nursing was echoed by most participants of the three focus groups and is summed up by one mentor who stated:

'I think the 'basics' is the most important thing. You find some people come in and say 'right we are doing bloods today' but what about washing the patient? What about skincare? What about the things that you are actually doing every day for your patient? I know the other stuff is important too but what about the basics? Basic nursing skills'.

All five mentors in one focus group identified that when determining learning opportunities for students, specific tasks were not their primary focus but they '*come with everything else*'. They

were clear that it is important for student nurses to learn about holistic nursing care and not compartmentalise nursing care by breaking it down into tasks.

The essentials of nursing care, such as assisting with personal hygiene, were considered to be vital skills and therefore the mentors were keen to impart this to their students. It was apparent that mentors felt strongly about their role in ensuring that student nurses placed as much emphasis on essential nursing care as they do on skills that are often seen as more technical and advanced skills such as venepuncture. Nevertheless, despite the mentors' insistence on the importance of 'essential nursing care', all acknowledged that students were very concerned with the mastery of task-based skills, venepuncture (taking blood) being a notable example, with one mentor stating *'A lot of [the students] like to do a task such as venepuncture'*.

The mentors did not label or compartmentalise specific skills, tasks or attributes as clinical skills but recognised that everything they do is 'clinical'. This was especially true of mentors from the other fields of nursing (e.g. mental health, learning disability) who clearly identified that they felt that clinical knowledge was a key aspect of clinical skills. Mentors from these fields replied when giving examples of what they teach student nurses in clinical practice:

'Quite a bit about the [Mental Health Act](#), adults with incapacity, about consent and capacity, around financial matters and so on. Also risk assessment and management'.

'A bit of work around different syndromes and stuff like that'.

'Quite a lot about the mental health act, care programme approach'.

Mentors were of the opinion that the term 'clinical skills' did not merely mean a task or psychomotor skill, but they reported that students themselves were still not clear about this. The mentors identified that the pre-registration students they had supported in practice still appear to be concerned with physical tasks and 'doing something' to someone, as described above in relation to the students wishing to learn how to take blood. This is akin to a task orientated approach that nursing has been attempting to move away from, in the desire to achieve a more holistic approach when delivering care. The findings show that the mentors in this study were not only ensuring that students have as many opportunities to learn, develop and master clinical skills as possible but they were also guiding students towards this holistic approach without denying students the chance to further develop more advanced skills.

4.2.2 Methods of teaching clinical skills

In the focus groups mentors identified how they taught student nurses in practice and the methods they indicated are summarised in Table 10 below.

Table 10: Methods of teaching student nurses in practice

Methods of teaching student nurses in practice
<ol style="list-style-type: none">1. 'See one, do one' method – when students watch nurses undertaking a task and then carry it out themselves.2. Student practicing on mentor – when students practice on the mentor before undertaking this on a patient or when students practice on the mentor only as there are no opportunities to undertake the skill on a patient.3. Using resources such as online videos and textbooks to illustrate (especially used when explaining anatomy).4. Demonstrating a skill – when mentors demonstrate the skill to the student and talk through what they are doing, explaining each step.5. Discussing cases with student –when mentors talk through cases and explain what has happened and why and encourage questions from student.6. Reflection – mentors encourage students to reflect, and encourage articulation of their reflections, on care delivered in practice.

Demonstration and the 'see one, do one' method was the most popular method of teaching task-based care as cited by the mentors in this study, especially procedures when the nurse effectively 'does something' to the patient. The 'see one, do one' method is when the learner observes the competent practitioner undertaking a skill or task and then they undertake it the next time there is the opportunity. This has long been used throughout nursing education, not just in clinical practice but in the simulated classroom environment. Therefore, this finding was not surprising. Mentors in all three focus groups identified the 'see one, do one' method as a method they would use and indeed this was the first method identified and discussed. This was also described by mentors as being a good method for them to use to assess students' current competence and whether their instructions as mentors were effective. As exemplified by one of the mentors:

'I like the 'see one, do one, teach one' [method], so I tend to do that. I show them first, then get them to do it and then get them to teach me'.

This also allows the mentor to check the student's theoretical understanding, as encouraging the student to talk through the skill or task helps the mentor to ensure that the student has grasped the underpinning knowledge and can apply this to practice.

When teaching students to undertake a clinical skill for the first time, and if there was no suitable anatomical model available, mentors reported allowing students to practice on them. This varied from taking a blood pressure to performing venepuncture. The mentors in this study were clear that they felt that this was entirely appropriate and gave the student the opportunity to practice the skill in a non-pressured environment before undertaking the procedure on a patient for the first time.

The mentors placed a great emphasis on talking through situations and reflecting on patient care as a method of teaching clinical skills, both during demonstration and after delivery of care. The use of reflection was mentioned specifically as a separate method from talking about cases and delivering care. In this respect, mentors stated that they used the professional key behaviours of questioning, encouraging thinking aloud, debriefing and reflection to help 'scaffold' their students learning. All mentors in all three focus groups alluded to using this approach in their teaching of clinical skills by which they meant not just reflection but also talking through cases and discussing practice. Some mentors identified using a mixture of the two; one mentor said:

'I talked through a couple of my cases and then introduced [the student] to the client and then reflected back on what we discussed and what they had found from meeting the client'.

Another mentor described the last time she was teaching students in practice in a situation where a client was at the end of life:

'I had two students with me at the time and I was explaining the importance of how this is the last thing you can ever do for somebody. Explaining why we do it, how we do it, different religions, just explain the whole cultural thing. How somebody dies and what is expected of us'.

The mentors in all three focus groups talked about how the time spent travelling between patients allowed them to undertake this discussion as soon as possible after they had delivered the care. Sometimes due to the long travelling time between patients this could be quite significant (up to an hour). The mentors all spoke about how this allowed them to '*really get to know [their students]*', their students' knowledge and also to debrief if this was necessary (for example, when dealing with distressing situations such as after a patient had died). They found they were able to learn about the student's experiences in other areas, what was new in clinical practice and in general get to know the student in an informal, friendly way. These relationships often continued after the placement ended with one of the focus groups talking about how when one of their previous staff members had been hospitalised for a time on the mainland, some of the students who had been in their clinical area made a special effort to visit them.

They stated that the privacy of the car could allow the student to ask questions and seek advice and feedback without the risk of other colleagues overhearing. It was valued by the mentors as it gave them the opportunity to provide one-to-one feedback in a more private environment. As one said: *'... it is good to be able to chat through stuff without anyone else around'*. In addition, the mentors said how it benefited them as well to spend journeys with students with one suggesting: *'It can be quite nice to have company'*.

In terms of other ways of teaching students, mentors reported arranging for students to work with other professionals in order to develop the students' clinical skills. Typically, the mentors described this as:

'Arranging for them to go with others from different specialities and [clinical] areas'.

The mentors viewed the students working with other professionals as important to see how the multidisciplinary team worked together and to learn from their observations, especially how the different professionals communicated with each other. They explained:

'We also try and get them involved in meetings and case conferences. So, they have experience of when all the services are together'.

All the mentors stressed how vital it was for the students they were supporting to experience as many learning opportunities as possible. If learning needs were identified that were either unavailable in their clinical area or there was an aspect of clinical care that they were unable to teach the student themselves, they would seek this learning out for their students on their behalf. Even before the students arrived to start their placement, the mentors spoke of how they would think of 'insight visit' opportunities that may be of interest to the student, as well as areas that they as mentors felt were key to the student's learning:

'When we know that there is a student coming, we all want the same thing and that is for that student to get a good experience and to learn and achieve that. We try to think of learning for them and try and get that sorted before they arrive'.

Insight visits is a term used in practice education in Scotland to describe when student nurses arrange to work with a different professional or visit and observe other clinical areas in order to gain a greater understanding of that professional's or service's work. For example, two of the community nursing teams were working closely with social care services due to the health and social care agenda and, as such, felt that it was of vital importance that students spent time with social care workers to gain a deeper understanding of their role within the multidisciplinary team. They explained:

*'I always get the student to go out with home carers, so they see what they do'.
'... and of course, we have our daily morning meetings joint with social care and*

the students are at that'.

Another example is enlisting the help of colleagues with clinical skills' teaching. In this case, two of the focus groups discussed how they would try and arrange a day with the practice nurse if a student had no experience of, or lacked confidence in, taking bloods (venepuncture). This was because this is a large part of the practice nurse role and they identified that repeated practice of a skill would help the student to master it. They would determine on which days their colleague was most likely to be undertaking this procedure (e.g. specific clinics) and arrange for their student to work with them on that day:

'I always try and get [practice nurse name] to take my student for a couple of days as it is a good way for them to get bloods done. I just call her and ask when she has the most [venepuncture appointments] booked in and the student goes with her then'.

Some of the mentors across the three focus groups alluded to being cognisant of different learner styles and modifying their approaches accordingly. The mentors did not talk at length about theories of learning, but they did refer to learning styles and how they 'taught' students in practice. One mentor said:

'People learn in different ways. Some can be really practical; some can be right into theory. There are different styles of learning. You've got to assess that student and discuss it with them. See what kind of learner they are'.

The other mentors in this group used non-verbal communication by nodding in agreement to indicate that they shared their colleague's approach.

One striking finding from the focus groups was that the mentors did not speak negatively at all when discussing their teaching of clinical skills. The study participants identified how being busy in practice neither affected their ability to mentor a student effectively or for that student to learn from their clinical experiences. Although mentors did acknowledge there were time constraints, they appeared to accept this as the reality but something that was not insurmountable and certainly not affecting their teaching. For example, instead of saying that a heavy workload could mitigate against them finding time to teach the students clinically, they saw ways around the busy periods. As one mentor said:

'Sometimes as well, something comes through the door and you don't have time to explain then [but you say] you'll explain later'.

Another suggested, in a slight variation:

'In an emergency I would involve the student and explain later'.

In reflecting on their own feelings about the teaching of clinical skills, mentors talked about the positive aspects for themselves. For example:

'I enjoy teaching. It's great to see their confidence grow'.

'I enjoy having students. I really do enjoy having students'.

'I don't see it as a burden but something that you want to do'.

None of the mentors mentioned ever having negative feedback from students and discussed how having the opportunity to gain positive feedback from their role of teaching clinical skills to students in practice gave them a great sense of satisfaction:

'It was nice to see that my student really enjoyed her time here. It was encouraging for me to look forward to having students in the future'.

4.3 Role of the mentor

The mentor's role of supporting students in practice has been shown to be crucial for students' learning and this is especially true when considering their experiences of teaching clinical skills in practice. Three sub-themes relating to the role of the mentor emerged from the focus groups: facilitation of learning, pastoral care, and professional development.

4.3.1 Facilitation of learning

The mentors in all three focus groups spoke about creating learning opportunities for students if these were not readily available in practice, due to the variable nature of workload in these remote and rural areas. One of the mentors typified the view of others:

'I think it is important that if you do have a quiet time that you don't just leave them to get on with things on their own. I don't like doing that. I like to teach them something. That is what they are here for'.

Indeed, the mentors in all three focus groups agreed that their workload fluctuated and could be 'quiet' at times. Some of the clinical areas could identify this in advance, and plan for students' learning accordingly, but not all could. Mentors reported that this could change very quickly, and geographical location meant that the number of staff resulted in a finite number of staff being available with skills to deal with clinical cases. The mentors suggested that they attempted to be proactive in identifying and facilitating learning opportunities during these times, as demonstrated by the mentor who stated:

'Forward planning [in these times] is quite important. We usually know if we can anticipate if it's going to be quiet'.

In this instance the mentor was clear that they felt that it was their responsibility to facilitate their student's learning and that it was important to 'fill up' the student's time with as much learning as possible. Various mentors spoke about how they went about this. One mentor stated:

'We will go through equipment like the resus trolley. We would go through a patient's Kardex and see what drugs they are on. Use the BNF to look them up. Things like that'.

Other mentors talked about delivering more formal teaching sessions either tailored specifically to the student or to other groups of colleagues and inviting the student to participate:

'We have done PowerPoint presentations for care staff and student nurses have come along to these and really enjoyed them. Pressure area prevention – that sort of thing. They have found it very beneficial'.

It was clear that those mentors who delivered formal teaching sessions very much enjoyed this part of their role, as evidenced by a mentor who said:

'I try to do something [as often as possible] whether it is a wee teaching thing or a case study'.

The mentors referred clearly to what they considered to be the key skills that mentors require when teaching clinical skills to student nurses in practice. Effective communication was one of the most frequently mentioned but they also talked about being 'patient' and 'supportive'. The mentors talked about the necessary skills as follows: *'having good communication skills'; 'leading by example'; 'being supportive'; 'having patience because not all students learn at the same rate'; 'being approachable' and 'having good personal insight'*. Mentors recognised that they should demonstrate good leadership skills as well as being an example to the students they teach.

They all spoke about the need to be flexible to support students in practice and that it was important to plan ahead for the students when they were arriving in their areas:

'I think it is good if you have a timetable set out for them at the beginning anyway so then if it is a bit quieter, they can go out with [the] Macmillan [nurse] or OT. You know – all the other kind of areas. You can work around that'.

The mentors talked about how they were proactive in using their entire team to help identify and facilitate learning opportunities for students:

'We think of anything within the whole team from north [of the area] right through to the south. Anything interesting that the other teams have that we can get the students to spend time there'.

In this instance the mentor in this focus group, when referring to other teams, meant colleagues in the team that worked in different geographical locations. It was also clear that this team approach was welcomed and that mentors enjoyed 'sharing' each other's students:

'It's good to have students coming into our small team [from other locations]'.

Mentors were also aware of facilitating learning opportunities to allow student nurses to experience the additional fields of nursing which are required as part of each field specific programme laid down by the Nursing and Midwifery Council. All mentors spoke about how they felt that they were able to offer these additional field learning experiences and planned for students to ensure they achieved as many of these as possible. One mentor who had previously been a student in the area in which she now worked as a registered nurse said:

'Mentors find it easy to signpost students to additional field experiences. When I was a student here, I spent time with lots of different people'.

They identified that this was due to numerous factors. For example, they talked about the fact that, within these smaller communities, healthcare professionals not only worked closely together but there were fewer members of the team which meant everyone knew each other well. They suggested that not only did this help the mentor to know who best to ask for an insight visit for their student, but close personal and working relationships meant that other staff were more likely to be accommodating in granting these requests. Also, the fact that the teams worked so closely together meant that mentors were more aware of colleagues' workload and when would be the best time to ask for their students to gain an insight visit. For example, one said:

'We all know each other in and out of work so it is fairly easy to arrange for people to take your student'.

'...yeah, we all know who is looking after who and what is happening so that helps'.

Again, mentors were proactive in arranging opportunities for their students to access these competencies before they started placement:

'We identify these before they come'.

'They can get a lot of their additional field experiences here'.

However, it was clear that mentors were careful not to assume what their students needed to gain from their placement and they also waited until they had their first meeting with their student.

'I find out what they are interested in and facilitate going out with other professionals to help meet these learning needs and interests'.

As a result of the very remote rural location of the clinical areas in which these mentors worked, many had additional training to care for patients out with their main field of practice. Some of the mentors, therefore, were aware that they had broader knowledge to impart to the students without the need for the mentor to arrange an insight visit, as outlined previously. One example would be the staff in the community hospital treating

children and young people in the emergency room or as inpatients waiting for transfer to another centre. None of the mentors were Registered Children's nurses but were expected to expand their knowledge and work within a larger scope of practice as this mentor illustrated:

'Paediatrics is something you would do more of here than anywhere else, so I think it's very useful [to have that extra knowledge]'.

Mentors did highlight some challenges. They stated that the lack of computers, inadequate Wi-Fi and no designated study area could be challenging for them and the students and that this could at times directly affect their role in facilitating learning for their students. The majority of the mentors identified this as a particular challenge as exemplified by the following quote:

'We don't have a designated study area. We don't have a library, we are short on computers'.

The fact that they did not have a designated study area for one team in particular was considered by the mentors to be a problem, as the clinical area was small with very few rooms available to use that were not already occupied; this meant that there was no assigned area for private meetings or a quiet area for students to study. The mentors in the community teams reported working in shared office spaces which they described as offering little privacy for having discussions with students and providing feedback. Within two of the community areas there was also little access to a public library or an alternative public space for students to use for study. Whilst the mentors in this focus group did report that staff were usually willing to accommodate meetings wherever possible, this was clearly seen as an aspect of their clinical area that was a disadvantage to students.

'The Internet does not always work, and the computers can be very slow'.

'Sometimes it can be difficult to access Wi-Fi'.

The lack of a robust and consistent internet infrastructure was specific to the mentors in the two focus groups at the greatest distance from the main centre. The focus group of mentors based in community within a town area did not identify these as being challenges at all. Mentors identified that good internet connections were vital in ensuring that they had access to resources to keep their knowledge and practice up to date, as well as giving them access to the key resources required to support their students' learning. Across the three focus groups, mentors had supported students from several HEIs and some from outside of Scotland, and therefore were not always experienced in the paperwork of their student's HEI. This meant access to correct paperwork online was absolutely essential, especially as all HEIs held the majority of mentor guidance electronically.

'Wi-fi – which is really important as that is where I go to check stuff about the OAR [Ongoing Achievement Record] and contact details for the Uni if they are from a Uni on the mainland'.

Mentors spoke about how they always tried to give students information about which mobile phone networks were available and where to access hotspots throughout the area. Student nurses were given access to Wi-Fi wherever possible, and mentors also provided information about where students could access public Wi-Fi.

It was not just technological resources that mentors highlighted. Some mentors identified a lack of resources such as space and other tangible assets to learn as being an issue as evidenced by the following statement:

'Not having easy access to resources. On the mainland you have an abundance of different resources around you'.

'We don't have a designated area where we can do teaching with them'.

The resources mentioned included not only rooms or space but other materials such as books, journals, anatomical models, and teaching mannequins.

Another potential challenge was that of the 'disinterested' student. One mentor stated:

'It depends on their enthusiasm as well ... that can be challenging. They are not [always] enthusiastic.'

However, this was only identified by one mentor across the three focus groups and was linked closely with the idea that some students are of the opinion that there are very few learning opportunities in a very remote rural clinical learning environment. As the mentor stated:

'Sometimes not all students think they can get a lot out of this placement here'.

The mentor did not clarify whether the disinterest had only been apparent at the beginning of the student's placement and whether this had reduced as the placement progressed. The mentors subsequently suggested that they felt that there was positive feedback from students who had been in placement and this was filtering down to other students coming to their areas. Thus, this was not in fact a significant issue for the majority of the students and was more likely due to the personal and ill-informed opinion of individual students. When discussing this, the mentors in all the focus groups became quite animated and it became clear that they took great pride in their communities and the work they do within these.

4.3.2 Pastoral care

The pastoral care of students is not an aspect of the mentor role that is explicit in the NMC (2008) Standards to Support Learning and Assessment in Practice. However, the mentors in this study did report that they felt that looking after the emotional needs of their students was necessary and that students' personal wellbeing was important to them.

The most pressing concern for mentors was a factor very much related to the geographical location of the clinical practice area in which they worked. The students coming to their clinical areas were invariably not from nor permanently resident in these geographical locations and so were expected to stay for between five and 14 weeks away from their usual home, as well as friends and family. Students feeling homesick was a specific challenge identified by mentors. They commented:

'If they are unhappy then it is going to affect their work here'.

'This can affect their learning as the weeks are going on because they are more homesick'.

Mentors discussed how younger students were more at risk of feeling homesick:

'They are away from families and friends and that can pose quite big problems for students especially if they are younger. Younger students get a bit homesick'.

Mentors talked about how they tried to take care of the students by making them feel welcome, ensuring their accommodation was suitable and asking how they were at regular intervals. As one mentor's comment indicated:

'I had one student for which this was her first time away from home and we got comments that we all treated her like mother hens and she really enjoyed her placement'.

The mentors in all three focus groups discussed the pastoral care side of their role out with the workplace too and agreed it was an important aspect of being a mentor. One mentor stated:

'As a staff team we were probably supportive out of work as well. You would give the students lifts to places and so on because they didn't know the area. That is never a problem'.

The mentors stated that was not an added burden but merely an aspect of the mentor role that their mentor colleagues in other placement areas may not have. Another mentor stated:

'I see it as part of the role. You need to look after your students'.

One notable comment was made by a mentor. When asked whether they saw the pastoral side of the role as an extra task or part of the mentor role, they replied:

'It is part of my role as a human being'.

The mentors make a distinction between ‘pastoral’, that is being concerned for a student’s wellbeing in so far as the mentor will ensure this within the confines of the workplace and their role as a professional knowledgeable colleague, and that of pastoral care that goes beyond the boundaries of the clinical area and is concerned with social wellbeing. The mentors mentioned giving lifts to students, signposting them to places of interest and introducing students to their peers within the community to further facilitate their immersion into the wider community in which they were working. At no time did any of the mentors in this study discuss inviting students into their own homes, meeting them socially outside work or any other activities that might jeopardise the student-mentor relationship. They were aware of not engaging in something that might affect the mentor’s ability to complete a final assessment of the student at the end of their placement. Indeed, the mentors talked about trying very hard to ensure the student nurses met and mixed with people of their own age outside the clinical area suggesting that:

‘We try and let them know good places to go out of work so they can meet people their own age’.

4.3.3 Professional development

One noticeable aspect of the data collected from the three focus groups was the overwhelming positivity of all the mentors who participated. Whilst this is a theme that runs throughout the majority of the data collected it especially seems to help mentors think positively about their own professional practice and development. One mentor stated that the expectations of being the knowledgeable practitioner and passing on their knowledge to students made them conscious of developing and maintaining their own knowledge base:

‘I often find it makes me question my practice so it makes me go off and learn stuff so I am able to pass that on – so it is about my learning as well as the student’s learning’.

Mentors reported that they found themselves checking the right way to do procedures and ensuring they were using evidence-based practice; rather than seeing this as a chore, they welcomed the prompt to keep themselves up to date. One mentor stated:

‘One thing I find as well is that you don’t pick up bad habits when you have a student here ‘cos you think this is the correct way to do it. I am going to have to do it to show them’.

All the mentors identified that they benefitted from reciprocal learning from students as these comments illustrate:

‘I learn as much [from them] as they can learn from me’.

‘Sharing learning [occurs between mentors and students]. They teach us as much as we teach them’.

Mentors mentioned how they would discuss clinical care with their student and ask about new ways of working that students had been taught about or even find out from students how some aspects of clinical care were delivered in other areas. The mentors also spoke about how the more inquisitive students, especially those who asked lots of questions, prompted them to think more about their practice and even at times question their ways of working. Rather than seeing students who ask a lot of questions as a nuisance they seemed to view them as a useful way of enhancing their own learning.

'They make you think [about why you do things a certain way]'.

'I would say I learn a lot from the students as well'.

4.4 Geography – Very Remote Rural Scotland

This study was specifically undertaken in a very remote rural area of Scotland as this is a distinct factor to be included within the context of pre-registration nurse education in clinical practice in Scotland and is a topic for which there is little research and, as such, a meagre body of knowledge. It was thought that this might influence and affect mentors' experiences of teaching clinical skills in practice and indeed it is a key theme that arose as the following section identifies. This reports the findings that relate to how the geography influences the context of practice of the clinical areas in which the students are placed, as well as how weather and other issues can affect the support mentors provide students in their clinical skills' teaching. Culture and society are also factors that mentors have identified as affecting the mentoring aspect of their role.

4.4.1 Working in a rural community

The mentors alluded often to how they felt their clinical areas may differ quite markedly from the previous placements students had experienced. The mentors in this study were aware that their clinical areas could be quite distinct to those in more densely populated areas. They recognised that the availability of services and the number of clinical staff present to deliver services is less in rural communities. Not only were there less staff but also many roles are occupied by one person with no immediate colleague on hand. Also, the number of hours of a service are reduced as compared to the hours of service available in other areas and in some areas certain professions may not be immediately accessible at all. For example, the local NHS board may deem it was only necessary to provide a community psychiatric nurse service for 21 hours per week (as opposed to another area where there is 24/7 cover) due to the sparse population. Thus, for the remaining time, someone who is acutely mentally unwell may have to wait for a community psychiatric nurse to come over on the next timetabled ferry and in the meantime non-specialist staff would care for that person.

‘Sometimes we are looking after people with mental health problems and they are really quite sick. We are not mental health trained and the CPN only works two days a week, so we have to wait for the patient to be taken off the island’.

In extreme circumstances the police or other professionals may have to become involved in that person’s care. Similarly, a patient who requires full time nursing home care may not be able to stay on their home island as there is no nursing home provision available and this means that relatives need to travel a couple of hours by ferry and road to visit their loved one. This also means that some staff are undertaking roles and delivering care that their counterparts in more urban areas would not be. For example, in the case of a patient who is acutely mentally unwell, nurses who are adult registrants would also be caring for that individual, having had some training to help support them in this role, and with the assistance of other health care professionals such as the local GP. Furthermore, some staff may be employed in a variety of different roles. For example, this may be a number of hours per week as a midwife, a number of hours per week as a health visitor and a number of hours per week as a community staff nurse.

However, rather than seeing this as negative or a potential challenge to teaching students, they saw this more as a chance to showcase their practice and seemed to see all the unique and different aspects as potential learning opportunities for their students. Mentors spoke about the role of the nurse as being more autonomous and covering additional fields of nursing at times due to necessity, as well as not always having access to medical colleagues. This was seen as different to other areas. The quote above relating to mental health is an example of this.

The mentors were keen to ensure that students benefitted from experience in such areas, as this comment shows:

‘[Being in this environment] teaches the students about lone working. Being competent enough to work on your own. Knowing when you have to phone for help’.

They also alluded to how the lone working aspect of their role helped students to learn about prioritisation which is a key skill that the registered nurses need to have.

‘Teaching them priorities can change instantly from whatever comes in’.

The mentors were also keen to show students that whilst not having medical colleagues immediately available was not ideal, it was not necessarily detrimental and that nurses can practise effectively in these circumstances:

‘I think because there is not a doctor you have to make more decisions yourself rather than if there was someone there to ask you would ask them. But you just decide for yourself. It is more of a responsibility. You are the one that decides when you want the doctor or not’.

Mentors were also keen that students were aware of the lower threshold for transfer to specialist centres, not just due to the lack of medical facilities and specialist knowledge available in the immediate local area. As one described:

'Having to get help quicker [is often necessary] as things can go downhill pretty fast here'.

Also, the availability of transport can be affected by adverse weather conditions and patients with greater priority in other very remote rural areas as exemplified by the mentor who pointed out:

'You can be waiting quite a while for the helicopter'.

Again, these comments, whilst highlighting potential service issues, were spoken about in a very positive way. The mentors were not complaining in a negative way that these were aspects of their role they had to contend with, but rather they embraced these added responsibilities as part of their job and accepted them as being inevitable facets of living and working in very remote rural communities.

Another key finding was that the mentors value the patients as key to the students' learning; indeed, it appears mentors see patients very much as another key partner in the teaching relationship. Instead of the traditional dyad relationship, mentors in this study seemed to be employing much more of a triad relationship with the patient or the community being the third member of the teaching group, as this comment illustrates:

'It is important that they get involved/immerse themselves in the community to understand the people they are looking after'.

The community in which the clinical area was located was also seen as unique and important for learning, in so far as the mentors all agreed that students learn as much about delivering nursing care by immersing themselves in the communities as by getting instruction from their mentors:

'You try and ensure that they get as many experiences as they can. From birth right through to death. So that they understand that we are not just community nurses, or a hospital nurse and it is people that you are dealing with on a daily basis, so it can be upsetting. You can be very close to these people as well'.

It is also clear from this comment that for nurses living and working within such a small community, there are aspects that colleagues who work in areas other than where they also live do not have to consider. The mentors suggested that in an island community, where there are a finite number of nurses available to work, it can be hard to avoid caring for patients to whom they are related or who are close friends. Thus, the mentors felt that

teaching students how to deal with such circumstances was useful. Mentors here were using the community as a teaching tool in itself.

From the focus group discussions, it was evident that mentors use patients as teaching 'tools' and resources for teaching clinical skills within a triad type relationship, as outlined above. As part of the nurse education programme in a university, HEIs often invite patients to come in and talk to students in the classroom setting about their experiences. However, in 'remote' community settings, with little or no easy access to a university setting, the mentors are far more likely to invite their patients to tell their stories so student nurses can learn from their experiences. Additionally, as one mentor stated:

'Patients like meeting them [in their own homes] and explaining their story'.

The mentors also discussed how patients not only like to showcase their own community, which they are very proud of, but also like to feel that they are contributing to the students' learning.

Even though the communities in which these mentors work are small, they did not think that students integrating into the communities would be an issue and it was not viewed as a negative. The mentors described how students were not seen as outsiders but as welcome visitors. As one mentor explained:

'Everybody knows they are students as soon as they arrive here [but they are still viewed positively in the community]'.

A further feature of working in a small rural community was that of people knowing each other well and the issue of confidentiality. As one mentor pointed out:

'I think confidentiality is a bit more highlighted here and that is passed on to the students because they will get asked things in the Co-op'.

Finally, the multiple roles of the nurse was also a feature of working in a remote community. It was highlighted that, due to the lack of services in some areas, it could be the registered nurse who has to undertake a job usually done by someone else and this might not necessarily be something healthcare related. One example of this is on islands where there is no undertaker; it would then be the registered nurse who would carry out many of the tasks more often associated with an undertaker's service:

'We appreciate that we may be doing other things (such as last offices) that nurses in other areas don't do – [but] we just do it'.

One comment that resonated in this respect was from one of the mentors:

'You can go into someone's home and not be able to work out why they are so upset but then find out their cow is stuck in the fence. You're not just a nurse! You can be a vet, you can be a midwife, you're a counsellor. You're not just a nurse, you are a bit of everything'.

This not only demonstrates how nurses in very remote rural areas are called upon to do what their colleagues in other areas might not, but it also shows how people in such areas are isolated and dependent on each other. From the conversations in the focus groups, it appeared that this perspective was being passed on to the student nurses who are on placement in these clinical areas, but in a positive way. Working in slightly different ways with other professionals was also something participants were keen to highlight to students. One mentor stated:

'Health and social care integration happened here years ago. We have always worked closely with social work and home care. We couldn't do our job without them and they can't do it without us. We have arranged for students to spend time with home care, so they are aware of the pressures that they are under to try and get people out of hospital. They found this was beneficial to them'.

4.4.2 Weather and associated issues

The weather and issues associated with inclement weather were highlighted as a challenge by mentors, especially with regards to travel, not just to and from placements but also during placements. In very remote rural areas of Scotland high winds can be quite common during the winter months. This includes hurricane strength winds which can cause travel disruption and damage to property. Whilst the weather was not seen as challenging for the mentors themselves, they did feel that it could affect the student experience and this in turn can affect their learning. The mentors alluded to how weather affected students' ability to travel to and from placement as well as the anxiety that travelling in adverse weather can produce.

'Weather can affect students if they are wanting to go home and come back'.

'Travel back and forth in the winter can be a [major] challenge'.

Travelling to every one of the clinical areas in which each of the focus groups mentors were based entailed a minimum of one ferry or plane journey and in one area at least two. Thus, not only was there the fear associated with perceived conditions of the journey during adverse weather e.g. rough seas or in-flight turbulence, but also the worries concerning cancellation of travel and the subsequent cost and inconvenience of finding accommodation. One of the mentors who had been a student in the clinical area prior to registration talked about the potential problem. This mentor was aware of the possibility of it being an issue because they had actually experienced the consequences as a student themselves.

'When I came to [.....] as a student I was stuck in [the port of] for two days, waiting for the ferry to sail [to the island]. It was awful'.

In these circumstances travellers cannot just return to where they started their journey as often the captain will be waiting for a break in the weather to sail, so passengers may not have much advance notice of the planned departure time. In this study it was clear that weather was identified as a potential challenge that could directly affect the students' learning of clinical skills rather than a challenge that specifically affects the mentor.

Mentors were aware of how students could become stressed from the journey and also that they may not be used to living and working in places with adverse weather conditions. The mentors reported how many students came to their clinical area with their own cars to aid their travel but were not used to driving on single track roads (especially when there is snow) or during stormy weather when driving across causeways may become hazardous, due to gusts of wind and overtopping waves.

'Students might not have driven on single track roads before and are not used to it'.

Mentors also highlighted how students may experience fear during stormy weather and the noise of high winds can affect their sleep. All of these factors lead to a heightened state of anxiety that can affect students' ability to learn. However, the mentors had been able to turn potentially negative experiences into a positive learning opportunity for students, whilst at the same time being sympathetic and mindful of the student and accommodating them wherever possible. This was done by helping the student identify how they were developing their own resilience and self-confidence in dealing with and overcoming their fears.

Other issues relating to the geography of the placement include finances and accommodation. Mentors reported that students could have a problem with finding suitable places to stay, and this could be very stressful.

'Sometimes accommodation for them down here can be quite hard to find and this is a concern for them.'

Not only may it prove problematic at certain times of the year to find this for the relatively long duration of placements, which can vary from five to 14 weeks, but it may not be fit or suitable. This can be the case, especially in the summer season in these areas which are popular with tourists. Not only does this mean that it is difficult to find suitable places, but it may also result in relatively high prices, making this unaffordable for students. This, combined with the difficulties of IT infrastructure and communications already identified as crucial to student learning, are issues that mentors concern themselves with. The location of the accommodation is also important as students who may have to stay at a distance from the clinical area's main office and/or at a distance from local services and amenities can be isolated. Whilst local people may be used to

driving up to an hour to go to the supermarket or sports facilities, this may be quite unfamiliar to someone who is used to having facilities within walking distance.

Nevertheless, the mentors discussed how the students' experiences gave them a greater appreciation of their patients' lives and how the weather and associated issues can affect the patients themselves. This can be useful for students who have worked or will work in clinical areas that patients are likely to be transferred to:

'They gain an appreciation that some patients may have to wait for treatment and transfer away. That they don't just get in an ambulance and travel to the nearest specialist unit'.

In conclusion, the mentors were both aware of the impact on travel difficulties on the students but still considered it to be a good learning opportunity, and one that helped students to empathise with the experiences of the patients they were caring for whilst on clinical placement.

... I think if they experience bad weather, they get a better understanding of how we work and how it affects patients that have to travel for appointments and treatment'.

4.4.3 Culture and society

All mentors in the three focus groups emphasised the importance of the local community and suggested that immersion in and an understanding of the community can be a vital learning tool for students. The people and the community itself were seen as learning resources in their own right.

'It is important that they get involved/immerse themselves in the community to understand the people they are looking after'.

Many areas of Scotland have very different cultures and societies. This includes not just a number of multi-ethnic communities but also some areas where Scottish Gaelic is spoken widely, or other dialects such as Scots or Doric. In the very remote rural area of Scotland in which the mentors in this study live, the Gaelic language and culture is very strong, and many elderly people speak Gaelic as their first language. Furthermore, there is a strong Presbyterian religious tradition in a large part of the area which affects many aspects of everyday life e.g. closure of shops and public services on a Sunday with a strong Sabbath (Sunday) observance. In other areas there is a strong Catholic religious tradition which again is firmly embedded in local culture and society. Students coming to these areas on placement may have experience of only one religious culture and can be surprised by the difference in what is often seen as a polar opposite religious beliefs. Also, they may not have experience of a community where religion is so deeply entrenched and again this may produce a degree of culture shock. The mentors in the study alluded to this in their rhetoric and saw this as important learning for the students.

'It is important that they [the students] know about the community. Church is important for the older people, so they need to know that and respect that'.

They identified that students need to have an appreciation of how religion affects their patients' everyday lives. One example is that some patients will abstain from taking certain medication on a Sunday to avoid the side effects that may not be conducive to spending a couple of hours travelling to and participating in a church service.

Whilst some students may be Gaelic speakers, most are not, and they can find it difficult at first if they are working in rural areas where Gaelic is spoken more than English. This can result in a feeling of alienation if the registered nurse they are working with is speaking Gaelic with their patient. Nevertheless, it appears from the data collected that the mentors felt it was important for students to understand how important the Gaelic language is for their patients and it may be the most effective way for them to communicate. For example, some patients struggle to find the right words in English to express themselves.

The mentors were keen to convey to the students that the roles of nurses were different, when working in this kind of setting. As one of the mentors stated:

'They [the students] understand that we are not just community nurses, or a hospital nurse and it is people that you are dealing with on a daily basis. You can be very close to these people'.

Another mentor talked of their patients' pride in their community and culture and how keen patients are to share this with students to help them gain a greater understanding. It was clear from the focus groups that the mentors actively encouraged patients to tell their stories as they felt that students benefitted from hearing about patient experiences and that this in itself was a useful learning tool.

4.5 Summary

This chapter presents the findings of the study in terms of the three themes. Data from the focus groups identified the mentors' views about clinical skills' teaching and the methods that the mentors used with the students, influenced by these community settings in a very remote rural area of Scotland. The findings have shown that the mentors deem clinical skills to encompass all aspects of clinical care given and this, in turn, is very much reflected in the methods of teaching they adopted. As well as using a specific demonstration model for teaching, they also advocated and widely engaged in other 'scaffolding' behaviours such as questioning, discussion and reflection to teach clinical skills to pre-registration nursing students.

The mentors in the study were all overwhelmingly positive about their role as a mentor. They appear to embrace their role with a real passion and take pride in talking not only about their knowledge and practice but their community. They are keen to use this to facilitate learning and the community itself has been identified as a third partner in the student's learning. Mentors see pastoral care for the student as an essential part of their role and demonstrate a strong sense of responsibility for the students' wellbeing whilst on placement within their clinical area, not just within the working environment but within the wider social community.

Importantly, the wider social community and the geography of that community were also identified as being factors that affected both student learning and how mentors supported and facilitated student learning in practice. These included aspects that were outside of the mentors' control but still elements which mentors must take into consideration when providing support. These were factors such as adverse weather affecting travel both to and within the clinical area. Adverse weather can also provoke anxiety and uncertainty for students who have never experienced that degree of severity before. Suitable and affordable accommodation can be difficult to acquire and this in turn can affect the levels of support that mentors may need to provide, as well as adding to student stress that affects learning. All of these aspects require the mentor to adjust their support and potentially even teaching styles and strategies.

It is clear from the data that they feel their role means they have some degree of responsibility in ensuring that they are supporting the student holistically to facilitate optimal learning. This may involve assisting students with aspects of their lives that are external to their roles as student nurses. However, what is also evident is that mentors embrace this and do not see this as a burden in any way. Indeed, one mentor summarised the other mentors' views on students; when asked about the positive aspects of having a student this mentor replied almost instantly with:

'I love it – they are a breath of fresh air!'

The next chapter takes these findings on further by discussing them in the context of the literature. This discussion will highlight both the similarities of the roles of mentors in different settings but also examines the apparently unique features emerging from the provision of clinical nurse education in remote environments.

Chapter 5 Discussion

5.1 Introduction

This chapter expands on the findings outlined in the previous chapter and compares and contrasts these with the existing literature. The key themes of clinical skills' teaching in clinical practice, mentors' views on their role in supporting and facilitating student learning and supporting student learning in very remote rural communities have been presented. This section will also address the finding that the community of the very remote rural community may be used by mentors as a partnership when teaching clinical skills to student's whilst they are on placement.

5.2 Teaching in clinical practice

This section will discuss the findings in relation to teaching in clinical practice and will examine clinical skills' teaching. The 'how' of clinical skills teaching by mentors in practice in the very remote rural setting will be examined, as well as the challenges to delivering this teaching as identified by the study participants.

5.2.1 Clinical skills

The literature has encompassed wide ranging opinions as to what is viewed as a clinical skill by health professionals (Kurtz et al, 1998; Simpson et al, 2002; Junger et al, 2005). Different domains can be included in what is considered to be a clinical skill and these vary from practical skills, communication skills, treatment skills to diagnostic skills. Michels et al (2012) identified that clinical skills are perceived in the main to include both practical procedures, clinical skills and treatment skills and that for the health professional to undertake a clinical skill they need not only to have the knowledge of how to perform the procedure but also the underlying knowledge and clinical reasoning. Indeed, without the three components, a clinical skill is merely 'a mechanical skill'. Much of the nursing literature that mentions clinical skills suggests that a clinical skill is not just seen as a psychomotor skill but also involves communication and clinical reasoning (Longworth, 2013; Mackenzie, 2015).

In Scotland, NHS Education for Scotland provide a clear definition of clinical skills as being any action performed that involves direct patient care which impacts on clinical outcomes in a measurable way (NHS Education for Scotland, 2007b). These not only include technical skills such as examination skills and invasive procedures, but also non-technical skills (often referred to as 'soft skills') such as communication, leadership and team working, as well as cognitive skills such as decision-making and clinical reasoning. As Rennie (2009) pointed out, this implies that

everything clinicians do for their patients (including actions, behaviours, and decisions) is a clinical skill.

As previously mentioned in the Findings chapter (section 4.2.1), many of the mentors identified the skill of being a guest in someone's home as important and as all the mentors were involved in visiting and caring for people in their own home this was to be expected. However, what was surprising is that this was very often the first skill cited. This is very important as, for most students, commencing placement within the community settings can be anxiety provoking due to the relative unfamiliarity (Carr et al, 2018). Students can find it difficult to adapt to delivering care within the home setting, without many of the resources (both physical and human) that are readily available within an inpatient setting (Anderson, 2009). Students can also find it challenging when encountering the varied and differing environments in which people choose to live. Studies have shown how students report difficulties in dealing with the distress they often experience associated with accepting and understanding patients' lifestyle choices and that they can often internalise this distress and worry and take it away with them (Sheick, 2011; Pritchard and Gidman, 2012). It seems that the mentors who participated in the focus groups are very much aware of the potential challenges for students commencing community placements and are proactive in managing this aspect of student learning.

The findings also showed that mentors do not see clinical skills as being merely those that are task based (mostly psychomotor skills) such as bed bathing, administering injections, wound care etc. The mentors in this study seem to consider everything they do as a clinical skill – whether it is 'hands on' or not. The mentors do not separate the notion of clinical practice from clinical skills. Clinical practice is defined in the Segen's medical dictionary (2012) as:

'A UK term referring to agreed-upon and customary means of delivering healthcare by doctors, nurses and other healthcare professionals.'

In this respect it is a term normally used to encompass all care given, whereas clinical skills are the actual actions performed to deliver that care (not necessarily hands on or task based). The mentors in this study do not seem to label or compartmentalise specific tasks and aspects of their job but recognise that everything they do is 'clinical'. However, they are acutely aware that student nurses do not always share the same view or understanding. This is echoed in current literature concerned with student nurses on placement within a community setting. Baglin and Rugg (2010) found that students were focussed on mastering clinical skills and did not identify holistic nursing assessment as a key skill they required. Baglin and Rugg's (2010) study was relatively small with only six participants; however, other literature has similar findings. Boxer and Kluge (2000) and Henderson (2002) also found that students' primary focus whilst out in clinical

practice was on learning, practising, and developing clinical activities. The mentors in this study appear to be in the main consistent in their approaches in educating student nurses about the holistic nature of clinical care delivery within their unique clinical practice environments but it is clear that there remains a disparity between the views of mentors and students. If there continues to be reporting that registered staff consider their newly-qualified colleagues to lack the clinical skills necessary to fulfil their role, then this points to the need to have a clearer and more universal definition of what is meant by the term 'clinical skills'.

5.2.2 The 'how' of teaching clinical skills in practice

As outlined in the literature review, there is very little research available that indicates *how* mentors teach clinical skills in practice. The research that does exist tends to focus on the barriers to effective clinical teaching, specifically teaching of a clinical nature that takes place within a clinical setting, with challenges identified as time constraints and the knowledge and skills of the mentor. However, McSharry and Lathlean (2017) undertook a study to explore clinical teaching and learning in an acute care environment in Ireland. They found that mentors also used the methods identified in this current study, in so far as students were found to learn by watching their mentor and then to undertake care in a way that was similar to the 'see one, do one' method, often used by the mentors in this study.

This resonates with much of the literature around 'how to' be a mentor as there are a number of texts written in the UK that seek to instruct mentors of student nurses and midwives on how to carry out their role (for example, Aston and Hallam, 2011; Kilgallon and Thompson, 2012; Wiggins and Heathershaw, 2013; Gopee, 2015). Indeed, the 'see one, do one' method seems to be so entrenched in practice that the key principles are identified as standing '*the test of time*' (Gopee, 2015 p80 - 104). Again, the wording of these texts further highlights that psychomotor skills and tasks are often labelled as clinical skills and thus could be further exacerbating this gap between theory and practice and what is deemed to be clinical and what is not. They also further reinforce the fact that clinical skills teaching is now a significant part of the role of the mentor in practice, rather than this being the responsibility of the Higher Education Institute.

Contrary to much of the research reviewed for this study, the mentors did not identify time as a constraint but accepted it as a reality that was not insurmountable, and one that did not affect their teaching. The mentors placed great emphasis on talking through problematic situations and time pressures and reflecting on patient care.

The mentors use the professional key behaviours of questioning, encouraging thinking aloud, debriefing and reflection to help scaffold their students learning. This is akin to the work of Vygotsky (Spouse, 1998b) and demonstrates that the mentors in this study use social interaction to promote social and cognitive development. Discussing and reflecting on care seems to be one of the primary methods in which mentors teach clinical skills in practice. It is clear that, whilst not explicitly reported, the mentors who participated in this study were all concerned with 'scaffolding' student learning in practice. They reported actively assessing students' educational needs by assessing their current level of practice and helping to scaffold their students' learning by seeking out appropriate opportunities to help develop their students' knowledge and practice.

Reflection in relation to health care and specifically nursing has several definitions but in essence they all are very similar. Dewey (1938) provided one of the earliest definitions and viewed the process of reflection '*as turning over in your mind a subject and giving it serious consideration*' (Kilgallon, 2012 p90). Schön (1983) furthered this concept by identifying two types of reflection. Firstly, reflection-on-action which occurs after the event and secondly, reflection-in-action which occurs whilst delivering care and both of these are used by mentors depending on the situation and the complexity of the care being delivered in relation to the stage of the student's programme. Learning through reflection was identified in the literature review (see section 2.3.3) as a technique often employed within the cognitive apprenticeship model of learning. However, much of the literature reviewed has found that mentors did not employ this technique regularly to facilitate learning with their students. It seems that, in this study, the mentors are quite unusual in their enthusiasm for this method of teaching. Another reason could be that with the implementation of revalidation for all nurses and midwives within the UK, mentors are more familiar and comfortable with the use of reflection as a tool to aid learning (NMC, 2018c).

5.2.3 Challenges to clinical skills' teaching in practice

Since the initial literature review was undertaken prior to the data collection, a number of studies have brought the mentor's experience of working with student nurses to the fore (e.g. Rylance et al, 2017; Lienert-Brown et al, 2018; McSharry and Lathlean, 2017; Bowen et al, 2019). Challenges identified from these studies include lack of time, unhelpful colleagues and the lack of remuneration for the role and this largely echoes previous findings (for example, Moseley and Davies, 2007; Kenyon and Peckover, 2008; Myall et al, 2008; Teatheredge, 2010; Jokelainen et al, 2013). The attitude of the individual student has also been identified as a factor, with mentors finding students who appeared disinterested and lacked motivation to be challenging (Rylance et al, 2017; Bowen et al, 2019).

Data collected in the three focus groups raised some pertinent findings for this topic. However, the only challenge to teaching clinical skills in practice that the mentors in this study identified that was also identified in the literature reviewed was that of the disinterested student. Some of the unique challenges faced by the mentors in this study were largely as a result of the geography, the practical difficulties of access, the importance of the communities residing in remote areas and the necessity of an extended role for nurses when registered and practicing in these areas. This echoes the experience of mentors in remote and rural areas in other countries. In Australia, where 25% of student nurse placements are in areas that are considered remote and rural, Bowen et al (2019) found that a lack of resources and an inadequate communications' infrastructure posed similar challenges as those reported in this study.

The weather and issues associated with inclement weather were highlighted as a challenge by mentors, especially with regards to travel not just to and from placement but during placement also. Whilst the weather was not seen as challenging for the mentors themselves, they did feel that it could affect the student experience and this in turn can affect their learning. This echoes the research findings from Canada where mentors also identified that adverse weather could be a source of anxiety for students and this could affect their learning (Killam and Carter, 2010). Yonge et al (2019) found that both mentors and students on placement in rural western Canada highlighted driving to and from placements in adverse weather and for long periods of time as factors that affected their learning. In this study the mentors alluded more to how weather affected students' ability to travel as well as the anxiety that travelling in adverse weather can produce.

In Chapter 4, it was shown that the mentors use the potentially negative experience and turn this into a positive learning opportunity for the student (section 4.4.2). This is an example of the all-pervasive positivity that was evident in the narrative in all focus groups. Interestingly whilst the mentors in this study identified that adverse weather was a significant issue, the only other similar study undertaken by Wisdom (2011), who looked at mentors' experiences of supporting students in an island board within NHS Scotland, alluded to weather in the context of students travelling to and from placement. The mentors in Wisdom's study did not identify this as a significant challenge to the student but that it may add to the mentor's workload as they seemed to be proactive in managing student travel to and from their NHS Board area. This suggests that within Scotland this is more problematic for the board in which this study was undertaken than for other island boards. Geography may play a factor in this as students attending placements within the area in Wisdom's (2011) study would be travelling from mainland Scotland to an island

board, whereas the students in this study would be travelling predominantly between islands and thus relying on smaller ferries and planes that may not be able to travel in bad weather.

Students feeling homesick was another issue identified by mentors and this is another challenge that was also identified in research from Canada and Australia (Killam and Carter, 2010; Webster et al, 2010; Smith et al, 2018). In these studies, mentors were found to be proactive in including the students in social events and helping to integrate them into the community, seeing this as important as a potential method of preventing potential homesickness and feelings of social isolation. Similarly, in this study it was also a challenge and a factor that was of high importance to mentors. How the mentors attempted to address this is discussed in the next section.

5.3 The role of the mentor

This section will discuss the role of the mentor and specifically the aspects of the role that were highlighted by the mentors in this study. This will include pastoral care, professional development, and the facilitation of learning in practice.

5.3.1 Pastoral care

Commitment of the mentor to their student is another quality that student's value immensely (Robinson et al, 2012). Much of the literature has identified behaviours related specifically to teaching and education in practice which include being knowledgeable about the programme of study, committing to regular meetings and sticking to these, demonstrating interest in nurse education and so on. However, in the case of providing pastoral care to students it is clear that simple acts of caring and kindness, not necessarily relating specifically to practice, can demonstrate the mentor's commitment to the student. These can be chatting about accommodation and if there are any issues the mentor can help with, asking how they are feeling, signposting them to social events and even introducing them to peers within the community, as was evident in this study. Mentors were clear that this was an essential aspect of their role and one that was crucial to facilitate an optimum learning experience. They noted that if a student were to learn and 'soak in' the experiences afforded to them, they needed to be free of any other worries and concerns to allow them to do this.

5.3.2 Professional development

This notion of reciprocal learning and helping the mentors to be more aware of their own professional practice was also echoed in the previous work of Wisdom (2011). The mentors in her study recognised that students had a positive impact on their own learning and professionalism and felt that it encouraged them to always ensure they were using evidence-based practice as

students will often ask questions pertaining to the rationale for care; as such, mentors were therefore keen to appear knowledgeable and up to date. Rylance et al (2017) concurred with this in their study of 169 mentors in the UK. The mentors were asked to comment on two questions whilst attending workshops. These were '*What gives you the most satisfaction about your role as mentor?*' and '*What causes most frustration?*' Not only did the mentors report that they felt mentoring students helped them to ensure they were up to date with their own practice, but it also helped mentors to reflect on their own practice. It was also clear that mentors valued the knowledge exchange that took place between student and mentor. Whilst little of the literature reviewed on mentoring in the UK identified this aspect, probably due to the fact that there is limited research that has looked at mentors' perceptions, the literature that has investigated mentoring in very remote rural areas in Canada and Australia has also found that this knowledge exchange relationship is valued amongst mentors (Yonge et al, 2013a; Trede et al, 2014). In one study, mentors were found to actively lobby to be assigned a student in order to further their own practice and learn new and up to date practices from the student (Yonge et al, 2013b).

The study participants alluded to the fact that they learned from the students as much as the students learned from them. This indicates that the mentors in this study did not appear to have any preconceived notions that they 'know better than the student' and they welcomed questions and discussion. Whilst much of the learning theory presented in Chapter 2 has discussed how the social nature of the clinical area supports the novice learner (for example, Lave and Wenger, 1991; Spouse, 1998a), this does not mean that the social nature of learning cannot apply to learning that is transferred from student to mentor rather than purely vice versa. The attitude of the mentors in being open to this shared learning, rather than being constantly the 'knowledgeable colleague' which inevitably leads to a power dynamic being evident in the relationship between student and mentor, may help the student's sense of belongingness and ultimately recognition as a valued team member. This reduction in barriers to learning can only promote learning in the clinical area and further supports the idea that learning within the social context is very important within nursing.

Another positive aspect identified was that mentors enjoyed having students coming into their various teams and this was not a finding in previous research reviewed pertaining to very remote rural placements nor was it something highlighted in the research into experiences of mentors in community settings. Indeed, whilst students are almost always positive about community placements and very much value the one to one teaching relationship between them and their mentor, much of the literature which alludes to mentors' experiences is quite negative. Whilst Ball (2017) wrote about how the potential new models of mentorship in the UK could be

employed within community teams, she highlighted the current issues with staffing and imminent retirement crisis that is facing community and primary care teams across the UK. Kenyon and Peckover (2008) used overwhelmingly negative language and words such as *'tensions'*, *'constraining'*, *'time consuming'* and *'difficult'* many times in their work on the experiences of mentors supporting students in practice.

5.3.3 Facilitation of student learning

When asked about the positive aspects of teaching student nurses, the conversation in all three focus groups broadened out to cover other areas and this captured much of the data that are unique to their placement areas. All mentors spoke about how they felt that they were able to offer additional field learning experiences and planned for students to ensure they achieved as many of these as possible. This was due to the fact that, in these very remote, rural communities, the mentors work very closely with colleagues and also engage in extended roles.

This was also found in research undertaken in very remote rural areas of Canada and Australia. Mentors reported that it was easy to arrange alternative learning experiences for students for several reasons. These include that there were less students competing for experiences in very remote rural areas and also that as nurse mentors and other members of the health team supervise less students they are happy to support students' learning (Webster et al, 2010; Yonge et al, 2013; Smith et al, 2018). The authors identified that this was due to the more inter-professional ways of working in very remote rural communities, whereby the closer working relationships aid the facilitation of additional experiences for student nurses and midwives (Webster et al, 2010; Yonge et al, 2013; Smith et al, 2018). Other reasons given included that as many nurses in very remote rural areas take on aspects of other roles such as social work, other fields of nursing and advanced practice, they are more aware of how these learning experiences will benefit and enhance the learning of the students they are mentoring (Lauder et al, 2001; Hounsgaard et al, 2013; Macleod et al, 2017). It is known that student nurses really value the opportunity to experience a wide range of learning whilst in clinical practice and this almost always leads to very positive feedback and reviews regarding that clinical learning area (Webster et al, 2010; Yonge et al, 2013; Smith et al, 2018).

As identified in the data, the mentors in all three focus groups spoke about creating learning opportunities for students in the event that these were not readily available in practice, due to the variable nature of workload in these remote and rural areas. This appears to be very unusual, not because the mentors talk about creating learning opportunities for students as the research reviewed has shown that mentors do this on a regular basis, but the fact that the mentors allude

to having the time to do this. As has been shown, much of the literature on the experiences of mentors in the UK is negative, and the lack of time to adequately support students is one of the most frequently cited frustrations for mentors (O'Callaghan and Slevin, 2003; Chuan and Barnett, 2012). It cannot be assumed, however, that since mentors in the current study did not refer to a lack of time as being a challenge when supporting students, this was purely the result of working in remote, rural areas. For example, Bowen et al (2019) found mentors in a remote and rural area of Australia also reported a lack of time to support their students' learning in practice.

In conclusion, the three focus groups identified experiences which are very similar to those reported in previous studies, but others that are markedly different. For example, mentors were less concerned with task-based procedures and viewed clinical skills as the totality of care delivered in clinical practice. Further, the mentors alluded to how they felt their clinical areas may differ from the previous placements that students may have experienced because of the geographical location, distinct community, and nature of service provision in very remote, rural areas in Scotland. However, rather than seeing this as a negative or a potential challenge to teaching students, they saw this more as an opportunity to showcase their practice and maximise the different aspects to enhance the learning for their students.

5.4 Supporting student learning in the very remote rural setting

It was clear from the findings that the rurality and remoteness of the study setting has a major impact, not only on the nature of mentoring and the kind of support that mentors were required to give but also on the type of care provided, and the challenges involved, to meet the needs of the community. This section discusses these aspects in terms of the role of the registered nurse and the impact this has in respect of nurse education.

5.4.1 The nature of the very remote rural community and the role of the nurse

The role of the nurse in the very remote rural setting was clearly identified by the study mentors as being more autonomous and covering additional fields of nursing at times, due to necessity. The mentors alluded to developing skills and delivering services which went much further than the normal scope of practice. This is echoed in much of the literature relating to mentorship in remote and rural areas in Australia and Canada (Pront et al, 2013; Oosterbroek et al, 2019; Yonge et al, 2019).

In addition, Housgaard et al (2013) described the nature of nursing in rural and remote areas of Greenland. They reported the wide range of traditional roles that nurses in this country fulfil

within the medical, nursing, psychology and social work domains, but they also noted how important cultural considerations are when planning and delivering care to the remote and rural communities.

In line with many very remote rural communities in Scotland, the dominant industries and occupations in a country such as Greenland, and the specific seasons associated with these, can impact on service delivery. Thus, Hounsgaard et al (2013) identified that nurses do not schedule check-ups and screening during the important hunting and fishing seasons in Greenland.

Similarly, there are times of the year when individuals are busy with local industries in remote rural Scotland, such as during lambing season when many crofting communities will be fully occupied, attending to their livestock, which will be their top priority. Another example is the local fishermen who are at sea all week and cannot easily access non-urgent care as their income depends on them working away from the land. In remote rural island communities in Scotland, the sea and maritime industries are major employers and thus many people of working age may be away for long periods of time, for example, in the oil industry or merchant navy and this can impact on care and how care is delivered.

5.4.2 Very remote rural communities' contributions to nurse education

The mentors who took part in this research demonstrated a considerable sense of pride in their community and the people living within this community. As mentioned previously, all the study mentors lived and worked in community settings that are characterised as 'very remote rural'. The community in which the clinical area was located was deemed important for learning, in so far as the mentors agreed that students learn as much about nursing by immersing themselves in such communities as by getting instruction from their mentors. The value of a local community is also highlighted in the literature pertaining to very remote rural placements in Canada and Australia. Smith et al (2018) found that students gained a sense of the culture and history of the indigenous populations that they were caring for by being part of the community, and that this was crucial for them to deliver effective care. This was echoed in much of the literature pertaining to very remote rural placements in Australia, in particular Webster et al (2010) and Daley et al (2013).

The relevance of this finding might be questioned in the UK and Scotland, as there is not the same kind of indigenous population as in Australia and differing cultures are often aligned with an ethnic minority or religion other than Christianity. However, as identified in the findings of this study, this is not the case within the Highlands and Islands; there is still a strong Gaelic language

culture and other beliefs and values, bound up in a traditional approach to rural and remote life, that potentially impact upon the education of nurses. For example, there are certain health beliefs and practices that are influenced by culture, religion and language. In Scottish Gaelic, the word for please is 'mas e do thoil e', which is relatively long and more difficult to say than 'please', so very often those who speak mostly Gaelic, when trying to converse in English, may not use the word and appear less polite. However, someone who resides in that community is aware of this and would not take offence at this omission, knowing that this is normal. Another example is medication compliance. In the Scottish Free Church, it is normal at certain times of the year for the church service to be quite long and, therefore, people will not take certain medications such as diuretics on Sundays, as they may cause them to need to use the toilet more frequently. Also due to the Sabbath observation, in certain very remote rural communities of Scotland (especially in the Highlands and Islands), there may be occasions when people cannot or are reluctant to obtain necessary provisions. For example, if someone contacted an out-of-hours health service and was advised to get a medication such as paracetamol they may not be able to do this as no shops would be open. They may also be unwilling to contact a neighbour or friend due to the culture of not disturbing people on Sundays. Similarly, working practices can impact on access to services. For example, during lambing season, crofters will often avoid any routine appointments because they are busy with their animals and have to work long hours. The crofting community are lone workers and would not employ someone else to stand in for them.

This research has shown that students learn from the experience of living and working in the very remote rural community which may have quite different ways of life. It allows them to develop an understanding of how culture, society and geographical location affect the individual's health beliefs and practices and their use of health care services. It also helps students to start developing broader skills such as confidence and resilience when encountering life in a community which is very different from their norm. In turn this has implications for the mentor's role in helping to develop nurses that can provide the most appropriate care for their patients.

5.4.3 Patients' contributions to nurse education

Service user involvement (i.e. the participation of patients, patient groups and third sector organisations to input into the development of the curriculum and in some cases assessment process) in pre-registration nurse education in the UK has been a requirement for at least the last ten years, according to the Nursing and Midwifery Standards for Pre-registration Nurse Education (NMC, 2010, p82). This continues to be the case in the new standards for nursing and midwifery education programmes commencing from September 2020 (NMC, 2018e, p.6). Although the process for this is not explicitly stated, the standards do require Higher Education Institutions to

outline how service users and carers contribute to student assessment. Stacey et al (2012) suggested that this was not without its problems, including issues such as a perception of a position of power the patient held over the student as an assessor and questions over the credibility of patients as assessors.

Nevertheless, this appears to be at odds with much of the research that has been undertaken to look at students' views on service user and carer assessments of their practice. Studies have shown that students found that patient and carer involvement in the assessment process allowed them to gain a more substantial insight into service user experiences (Duxbury and Ramsdale, 2007; Terry, 2012; Speers and Lathlean, 2015). Davies and Lunn (2009) found that students found patient feedback helped them make positive changes to their clinical practice and that the feedback they received was both non-threatening and non-judgemental.

In this research the mentors do not specifically mention patients as an important partner in assessment but see service users and carers as integral to student learning; they appear to believe that by patients telling their stories they are adding to the students' learning. They valued the patients as key to the students' learning and saw them as another key partner in the teaching relationship. Instead of the traditional dyad relationship, mentors in this study were employing much more of a triad relationship, with the patient being the third member of the teaching group.

Patient stories have often been used to enhance student learning by enabling service users and carers to tell of their experiences with a view to inform clinical practice. Several studies have identified the use of service users to generate learning resources or to share their experiences with students within the classroom setting (Christiansen, 2011; Rhodes, 2013). These studies have showed that patient stories are powerful and can provoke strong emotions within students. This not only enables students to think about care delivery but, also, they form a significant learning tool, as students remember the stories. In these studies, the stories were digitalised or recorded on paper so that the patients were not actually present in the classroom setting. Gidman (2013) interviewed twelve nursing, midwifery, and social work students about their experiences of listening to patient stories whilst out in clinical practice. The students not only reported how valuable listening to patient stories was to further their own knowledge and understanding, but also that by taking the time to listen to others' experience it enabled them to develop therapeutic relationships with their patients. They valued hearing the patient perspective and felt that this further increased their commitment to delivering person centred care.

Service users have also been involved in speaking directly to student nurses in the classroom setting. The ability to hear a service user speak about their symptoms and experiences, as well as the listener being able to ask questions, was seen as invaluable by a cohort of mental health undergraduate student nurses in a study by Schneebeli et al (2010). Indeed Feijoo-Cid et al (2017) reported that students felt that service user and carer stories as a learning resource provided them with a humanised perspective of care. This indicates that the use of narrative pedagogy is widely supported in the literature and digitalised service user and carer stories are increasingly being used (Waugh and Donaldson, 2016).

The mentors in this study were not referring to 'story telling' in the above sense as a way of promoting student learning. Rather they were supporting the value of face to face contact that students gain when hearing patient stories from them in real time. By speaking to patients in their own homes, students have the chance to learn more about the service user. They can get a sense of their likes, hobbies, values, lifestyle, and spirituality. Students may develop an understanding of their family and social circumstances, and even a glimpse into their patient's life history through family photos, pictures on the walls, and books on the shelves. Furthermore, the student can gain valuable information from being able to see someone's body language. Patients' life stories, experiences and current health or illness status and how the patients interpret this is the teaching resource or 'tool'. This is where it can be argued that the patient is an important part of a 'triad' relationship, integral to student nurses' learning.

5.5 The Triad-Community model of learning in nursing practice

The findings of this thesis have led to the proposal of a model of learning in nursing practice (see Figure 1), which describes the potential relationships between patient, student and practitioner as well as recognising how culture and society and geographical (physical) location influence learning in practice. To reflect the changes in student nurse supervision and assessment (NMC, 2018b), the term 'practitioner' will be used for 'mentor', 'practice supervisor' and 'practice assessor'.

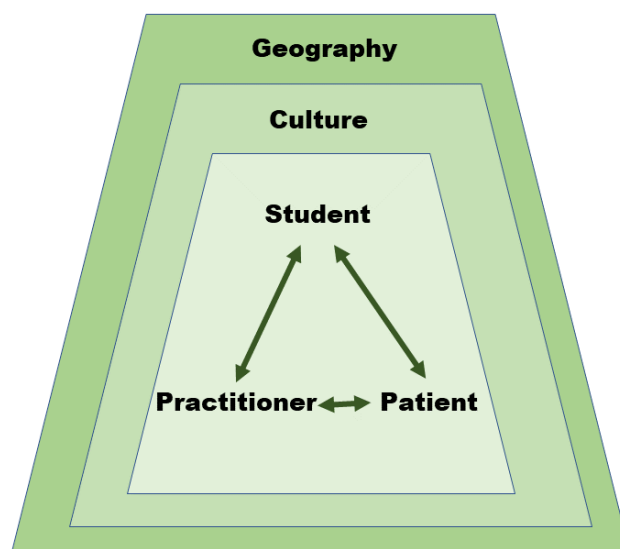


Figure 1: The Triad-Community model of learning in nursing practice

This study strongly supports existing theories underpinning learning that suggest that healthcare professionals (including nurses and midwives) develop their skills, knowledge, behaviour, attitudes and values from working with and copying those of role models in practice (Gopee, 2018 p57). Learning takes place in social situations and Situated Learning Theory suggests that learning occurs when the student becomes involved in a 'community of practice' and alludes to this community of practice as being groups of people who are working within a shared professional sphere (Lave and Wenger, 1991). However, rather than the 'community of practice' being a physical community, Wenger (1988) identified this as a community of professionals. The findings of this study suggest that learning does not merely occur within a community of fellow health professionals, but it also takes place within the geographical location, culture and group of people that the community of professionals 'serve'. This thesis proposes that the recognition of the physical or geographical community is just as important as the professional community for student learning in clinical practice.

The findings of this study suggest that whilst there are indeed 'Communities of Practice' in so far as there are professional communities but that there are also 'Communities of Learning' and central to these communities of learning (which are influenced by culture and geographical location) is the 'triad' relationship of patient, student and mentor. This is not a new concept as such and has been identified in the literature (Plack, 2008; Cobb et al, 2017). However, this is currently embraced more within allied health care professionals and a search of the literature for the 'triad' relationship in nurse education found that the concept of the triad pertained to the

third partner as being a resource or fellow (albeit within a different role) health care professional (Mather and Cummings, 2015; Divya et al, 2020).

Also, it is important to move away from considering 'knowledge exchange' as being a one-way process (practitioner to student) and to recognise this transfer of knowledge works both ways. Furthermore, knowledge exchange does not merely happen between registered practitioner and student but also between service user/patient and student and vice versa, as well as between registered practitioner and service/user patient. Knowledge exchange is essentially a cyclical process which is not just confined to student learning from patient or practitioner, but the learning occurs continually and flows both ways. Since there is often a triad (patient, student and registrant) present during care delivery, it could be further suggested that knowledge exchange occurs within a triad and that in practice learning, nursing education should be deviating from thinking of a 'dyad' relationship but that or the 'triad' relationship encompassing and recognising the importance of the patient or service user.

As well as recognising the importance of the patient and service user in nursing education, the 'triad' concept further identifies that all members of the triad learn from each other and teach each other. This is demonstrated in the inner part of the model picture, where it is clear that there is this constant flow of information or 'knowledge exchange' between all members of the triad.

This model also builds on the social nature of learning and recognises that learning and knowledge exchange is not limited to either a formal location (e.g. university building) or a formal process (e.g. meeting between practitioner and student) but is happening all the time in an informal manner. This can be from the chat in the car between practitioner and student reflecting on a recent visit to a patient recalling her experiences of having her baby at home in the 1950s and how different it was from her granddaughter's experiences of having to travel to have her baby. This model recognises that it is the patient or service user stories, and how others interpret and understand their own life experiences, that can educate nurses in practice just like attending a lecture on anatomy and physiology does.

Furthermore, the external influences of culture and geography can be used as learning tools that members of the triad can use to learn from and teach others, as well as being standalone learning tools. In this model the term community is not now being used as a term to describe a group of professionals sharing the same goal and sphere of practice but refers to geographical location, population and culture in order to recognise the potential learning offered by including the

experiences and life stories of those living in specific communities. It further recognises that physical location (geography) and culture are separate but influence each other and ultimately the triad involved in knowledge exchange. For example, people living in these very remote rural communities will not have access to the same leisure facilities as people living in more populated area. This will affect the way they perceive and access certain areas of culture such as entertainment, music, and the arts. Social gatherings will differ greatly and may entail a much smaller social circle leading to a different social learning experience for the members of that community. The weather may affect daily life. In an area prone to storms, the population may experience disruption in access to aspects of daily life such as education, procuring groceries and even attendance for health services. Power cuts may mean loss of communications for prolonged periods of time. All these factors may aid the student experiencing these or hearing from others about their own experiences in developing their own sense of resilience and self-confidence, which are key skills required for practitioners. This model is based on findings from a study undertaken in a very remote rural community in Scotland but this does not mean that the key concepts of the model i.e. the triad at the centre of learning and the influence of culture and physical geography are not applicable to all communities across the UK and even beyond.

5.6 Nursing Education in general

The findings of the study have shown how important the significance of culture is in nurse education. They indicate it is crucial that nurses are aware of how culture can affect the service user's health beliefs and behaviours and their experiences of accessing health services. The research has showcased this within a very remote rural area of Scotland, but this applies across the UK and the wider world. It has also highlighted that the concept of what is thought of as culture needs to be further examined and that it is important that nursing students become aware that culture is not something that is restricted to a group of people defined by their spiritual and religious beliefs, ethnicity or specific way of living. Culture is influenced by so much more than this and different 'culture' exists that are defined by many other aspects including geographical location. This geographical location can be as extensive as a country and as small as a clinical area e.g., an intensive care unit. The promotion of the culturally competent health care professional is an emerging agenda that can only help highlight this important aspect of student learning and should encourage staff supporting student nurses in practice to include this in their teaching and recognise the importance of patient and service users' experiences and voices in this regard.

This concept of using values-based learning to enhance student nurse education in practice is one that is applicable across all learning environments, again both in the UK and worldwide and it is

another example of the generalisability of the findings of this research. This research has shown that staff supporting student nurses in practice are encouraging student nurses to recognise and respect the service user's values and by determining these, use this to further their learning in practice. This is also aligned with the findings that the mentors in this study are concerned with teaching student nurses about the being of nursing. They make it clear that clinical skills to them are not just the psychomotor skill of doing a task in relation to a patient but that it is impossible to separate skills and caring for a patient. All care is a 'clinical skill'; delivering care for a patient is so much more than undertaking a skill that will hopefully bring about a specific result. Being a nurse in the fullest sense and working with the patient is so important. Being a nurse encompasses walking beside the patient and not just doing to or for the patient.

5.7 Summary

In conclusion the discussion of the findings of this study has shown that mentors value their role in teaching clinical skills to student in practice. In this very remote rural area of Scotland, they enjoyed this opportunity and actively invited students to consider clinical skills not just being a psychomotor skill or task but that all aspects of the nursing role are clinical. The findings identified clearly that the mentors in this study were actively using the theory that they had been taught in their initial mentor preparation and thus this would be valuable to consider including in future preparation for those involved in supporting student nurses in practice.

This research has found that mentors actively involve their community in providing learning opportunities for students in these very remote rural areas. They included patients and service users but also used culture and physical geography as tools for learning. From drawing on the experiences of the mentors it became clear that the concept of a 'triad' is central to student nurses' learning in the community setting and as such the Triad-Community model of learning in nursing practice was developed to demonstrate this. Chapter 6 reflects on this and provides recommendations for future knowledge and practice based on these findings.

Chapter 6 Conclusions, reflections, and recommendations

6.1 Introduction

This chapter presents the conclusions, reflections, and recommendations arising from this study. The key research conclusions are identified alongside a consideration of the research process and its strengths and limitations. The potential contribution of the findings of this study to both practice and knowledge are acknowledged and finally the recommendations for future research will be outlined. The aim of this research was to explore the experiences of nurse mentors in a very remote rural area of Scotland and as well as gaining a picture of their experiences, sought to fill a gap in current knowledge. The research aimed to answer three key questions namely:

1. What are the mentors' experiences of teaching clinical skills in a very remote rural area of Scotland?
2. What do nurse mentors consider to be the clinical skills that they teach student nurses?
3. How do mentors teach these clinical skills in practice?

Data answering all these questions was obtained and interpreted and as a result a model of learning in community practice was proposed that is potentially applicable to all types of community setting be them urban or rural. This includes the notion of a triad relationship between patient, practitioner and student as being central to student learning.

6.2 Research conclusions

This study has determined the experiences of a group of mentors living in a very remote rural area of Scotland's with regards teaching clinical skills to student nurses whilst on placement in their clinical areas. A total of eleven mentors across three community teams participated in three focus groups, all of which were undertaken within their own workplaces. This sample consisted of the majority of the mentor population within these three teams, as only two mentors from these teams did not participate. In one team, the focus group consisted of all of the mentors in that area.

All of the students allocated to the mentors in these areas are required to travel a distance from their main campus to reach the clinical areas and these journeys always entailed either a ferry or a plane journey and sometimes more than one leg to their journey. Students on clinical placement in these areas are required to stay away from their main residence or home for between five and fourteen weeks whilst on placement.

Literature pertaining to educational theory and nurse education in practice was reviewed prior to the study, as well as that relating to student nurse experiences in practice. It was clear from the literature review that whilst there are many studies that have examined student nurses' experiences of learning whilst on placement in clinical practice, there is very little evidence regarding the experience of mentors supporting students in practice and even less that has sought to examine mentors' teaching practices in clinical practice. Therefore, research to determine mentors' experiences would add to the body of knowledge relating to practice learning in nurse education in the United Kingdom. This would specifically relate to learning in community teams and practice learning in very remote rural areas. However, whilst this study was undertaken in Scotland, this could also apply to very remote rural areas within the other nations of the United Kingdom.

The research has been undertaken using a case study approach and focus groups were chosen as the method of data collection. This proved to be an effective method as a significant amount of in-depth, rich, and illuminative data were collected. The focus groups were recorded, and notes taken at the same time, which proved useful in recording the non-audible data such as body language and facial expressions.

The mentors who participated in this study identified a number of clinical skills they taught student nurses who were working with them on clinical placement. Several skills and aspects of clinical care were mentioned that were to be expected. However, one of the key findings was that mentors were keen to ensure that the students they worked with could deliver essential nursing care and see this as a priority. They were also clear that students needed to be prepared for delivering nursing care for people in their own homes. They spoke about how important it was for them to ensure that students behaved in the proper manner when entering a patient's home and that they were clear that they were there as a guest. Mentors were aware of students drive to acquire clinical skills as soon as possible, especially skills that are seen as more advanced such as venepuncture. However, the narrative from the focus groups suggests that these mentors are trying hard to get students to move away from a task-based philosophy of nursing to seeing their patients in a more holistic manner.

The study participants also spoke of how they taught clinical skills in practice and cited a number of methods. These included practicing on the mentor, using resources, arranging to go out with other health professionals and showing the student. The main method used was the 'see one, do one' method, especially when teaching a psychomotor skill. The other most often mentioned method involves reflection and discussion of patient care and case studies. All the mentors talked

about arranging for their students to go out with other healthcare professionals both as a means to learn and further develop skills that were out with the mentor's cope of practice and also to achieve learning outcomes relating to additional fields that students must undertake before registration.

The challenges or negative aspects of teaching clinical skills that were identified in this study by mentors was the lack of resources to aid their teaching and the disinterested student though even these were not spoken about in any depth. The study participants discussed situations which may have been identified as challenging, but this was not the case. When discussing being busy, mentors spoke of how they got students involved at the time as much as they could and then took students aside later and discussed the care given and answered any questions. They did not suggest that being busy affected their role as a mentor, neither did they speak about how the students were an added burden at busy times. In fact, the positive attitudes of all the mentors who took part in the three focus groups was clear. The atmosphere in the rooms in which the focus groups took place was for want of a better word 'buzzing', the mentors lit up when speaking about their experiences having students and the body language displayed was open, smiling and welcoming. Even the fact that the mentors felt obliged to provide pastoral care was not perceived as an added burden. Comments from the mentors who discussed this indicate they felt this was not an addition to their role but merely something one human being does for another. This positive attitude of mentors is a key finding from this study.

Another key finding is how mentors use their community (geographical location and the people who live there) as partners and tools in which to assist them with teaching student nurses clinical skills in practice. They spoke about the importance of students immersing themselves into the local community to gain a greater understanding of culture and how this can affect the health behaviours of their patients. Also, they considered that patients, families and carers could be powerful narrators, telling the students of their history and experiences to provide students with a greater understanding of the patient experience of health conditions and using health services. Furthermore, they identified that certain aspects of these communities such as adverse weather and its consequences, can help student nurses develop skills that are vital when delivering nursing care such as self-confidence and resilience.

6.3 Reflections on the research process

When I first started my EdD, I had no idea that this would culminate in a significant journey, both within my own development as a researcher and professionally in a change of career. This thesis stemmed from both observations of the work mentors undertook in supporting students in

practice in the role I occupied at the beginning of my EdD journey and the results of my MEd research project that examined specific teaching behaviours observed in practice. Undertaking a doctoral degree has allowed me to become immersed in my research and explore the data collected in depth. The nature of the research has meant that I have been given the opportunity to gain a greater insight into the experiences of mentors as well as showcase this to a wider audience. A more thorough understanding of the influence of the wider community on student nurse education has proven invaluable in signposting both practice supervisors and students to learning opportunities and how to harness these to further their knowledge and practice.

The initial study I undertook within the first year taught me a great deal about how much I still needed to develop as a researcher. Undertaking an initial study gave me the opportunity to take some time to reflect on how I had undertaken this, review current literature and theory and identify a plan for how to go forward with my research. I was aware that, in order for me to gain an understanding of mentors' experiences of teaching clinical skills in practice, I needed to use a method of data collection that would allow for the generation of rich data, discussion and personal anecdotes. The doctoral degree process has enabled me to grow as a researcher and I welcomed the structure and support provided during this time. The opportunity to work in a community of fellow researchers and learn from their knowledge and experience was one that was invaluable to me and to my professional development in this area. Had I not had this opportunity I would not have furthered my own skills and been able to showcase the experiences of mentors in very remote rural areas of Scotland.

6.4 Strengths and limitations of the research

One of the key strengths of this research is that the participants worked together in teams and also represented the majority, if not all members of their team. This allowed for the data to reflect a full picture of the individual and group ideas, approaches, and experiences within their specific geographical locations. Another key strength is the fact that this is the first time that data on the experiences of nurse mentors working in this particular very remote and rural area of Scotland have been gathered by means of a robust research study.

It might be considered that since the research was undertaken in a unique area of Scotland, this could limit the scope of application to practice and knowledge. However, the key findings, their theoretical underpinnings and how these could further contribute to knowledge and practice are potentially applicable across the country. In particular, the model of learning that has been constructed as a result of the key findings could also have global relevance.

6.5 Contribution to practice

The current model of supervision in practice for student nurses and midwives is set to change in the United Kingdom from September 2020. Student nurses will no longer be allocated a mentor who is responsible for both supervising and assessing their practice. Instead student nurses and midwives will be allocated a separate supervisor and assessor. The supervisor will supervise them in practice and be responsible for facilitating learning opportunities and teaching clinical skills as required. The assessor will be responsible for completing the student's assessment in practice through direct observation of the student, as well as taking into account feedback of their practice supervisor.

Other changes include taking away the requirement for a student to work with a mentor 40% of the time and for the supervisor to supervise a maximum of two students at any one time. This is to allow for more flexible models of supervision, to be decided at a more local level to suit that environment. Furthermore, the current requirement for all mentors of student nurses and midwives to undertake a formal mentor preparation course which must be delivered by an HEI institution at least at undergraduate level has also been withdrawn.

From September 2020, supervisors and assessors will need to be adequately prepared for the role but formal preparation will no longer be required. The need for annual mentor updates is unclear, but within the new standards this is not explicitly mentioned as a requirement as it has been previously. This study has shown that the mentors involved were knowledgeable about teaching methods and which ones were effective in teaching clinical skills to student nurses in practice. All the mentors in the study had had regular annual mentor updates and the majority had undertaken formal mentor preparation. This would suggest that future supervisors and assessors may benefit from learning the same educational theory regarding teaching and assessment that current mentors have received. One of the key recommendations from this study is that although the requirement for formal mentor preparation has been removed, future adequate preparation of both supervisors and assessors should contain key educational theory to help those supervising students have a good understanding of the best methods of teaching clinical skills.

All the mentors in all three focus groups discussed and agreed how important it was for students to be prepared to deliver nursing care within the patient's own home. Providing care for someone in their own home and in an environment, which is completely different from a healthcare environment such as a hospital or clinic setting requires nurses to be aware of how they must act in a respectful manner and remember they are a guest in that place. Therefore, another recommendation from this study is that this topic is covered in the classroom in the student's HEI

before students are placed in a community setting. It may be that some Universities are already including this in their curriculum, but this is not universal throughout the United Kingdom at present. This study suggests this should be implemented across the UK.

6.6 Contribution to knowledge

This research has identified that community culture, society and physical location is an important aspect of student nurse learning. This is especially true in very remote rural communities but can also apply to any community and is not just limited to practice in a community setting but could be applied within the in-patient clinical environment. This study suggests that it is not merely traditional 'dyad' relationship between teacher and learner at the centre of student learning in practice but that within clinical practice the patient or service user is an equal partner in this dynamic and must be considered to be as much of a teacher as the practitioner. Therefore, we should consider there to be a triad at the centre of learning in practice and move away from the more traditional notion of the dyad. Also central to this is the fact that due to the social nature of learning, all members of this 'triad' are constantly learning from each other (regardless of their 'role') and teaching each other. The environment within which they reside also influences this learning. The physical and social aspects of that community impact on each member of the triad's experiences, knowledge and understanding and this is constantly shifting depending on the changing nature of the community in which they are in.

6.7 Recommendations for future practice

The findings of the study have suggested that there are many aspects of the previous manner of preparation to support learning and assessment in practice within the UK which remain valuable and that the Nursing and Midwifery Council and NHS Boards and Trusts should consider that theoretical aspects of learning and teaching remain a core element of future practice supervisor and assessor preparation. As preparation programmes for future practice supervisors and assessors of student nurses and midwives in the UK move away from formal courses delivered by Higher Education Institutions, it is important that those delivering preparation ensure that this aspect is included in content and that those involved in educating practice supervisors and assessors have the knowledge, skills and experience to facilitate this learning.

As well as ensuring that practice supervisors and assessors are prepared to support student nurses and midwives in practice, it is also recommended that students receive preparation specific to the community learning environment. The research has found that students do not seem to be as prepared for working in a patient's own home as they do within clinical environments such as hospitals and health centres. Specific learning identified included how to

act in the home of another, being a guest in that person's home and working within a setting that is not set up to be explicitly clinical. A study conducted by Oozageer Gunowa *et al*, in 2018, showed that simulated practice helped students prepare for such a situation. They facilitated three scenarios based on visiting a patient in their home. This was sited within the university campus, but the rooms were set up as if they were living rooms and the students had to enter and leave the rooms as if they were visiting someone at home. This evaluated very well and similar opportunities afforded to student nurses may be one way of achieving this. As the drive to move care out to the community this seems more important than ever.

A final recommendation is that nurse education providers and those that support clinical experiences for student nurses consider the Triad-Community model of learning in nursing practice. Consideration is given to recognising the importance of the 'triad' relationship between students, practitioners, and patients and that more emphasis is given to the role of the patient and service user in nurse education. Furthermore, this moves away from the notion that patient and service user involvement must be formalised and sited in an academic context, but recognise that this can be utilised in an informal way and that this is just as valuable as a 'formal' partnership. Knowledge exchange in formal education occurs in informal and unplanned ways and can be just as effective when it happens in an opportune way. Also, those involved in nurse education recognise that physical geography and culture influence not only patient and service users' experiences of health care delivery and their health behaviours and beliefs but that they also influence student nurses and practitioners learning. How they experience these can help them develop invaluable skills for their future nursing practice and ultimately this occurs not only in unique communities but across the UK.

Postscript

Clinical skills teaching by mentors of student nurses in very remote rural Scotland was the original title of this thesis. However, what started out as an investigation into how and what clinical skills mentors are teaching has ended up as so much more to me. Not only has this study allowed me to evolve and develop as a researcher but it has allowed me to showcase a small part of the world that I hold dear. It is also such a privilege to give a voice to my colleagues and allow them to tell their story. A story, which in turn has influenced a potential new way of thinking about learning in practice and one that recognises the invaluable contribution of service users in the education of nurses – both students and practitioners alike. Their stories have highlighted the importance of the influence of culture and physical geography on learning and enabled me to identify a potential model of learning in community practice.

I end this thesis with a picture that for me sums up my experience. This was taken by me on my way back home from undertaking one of the focus groups and for me illustrates the beauty of very remote rural Scotland and the journey that I have been so fortunate to take.



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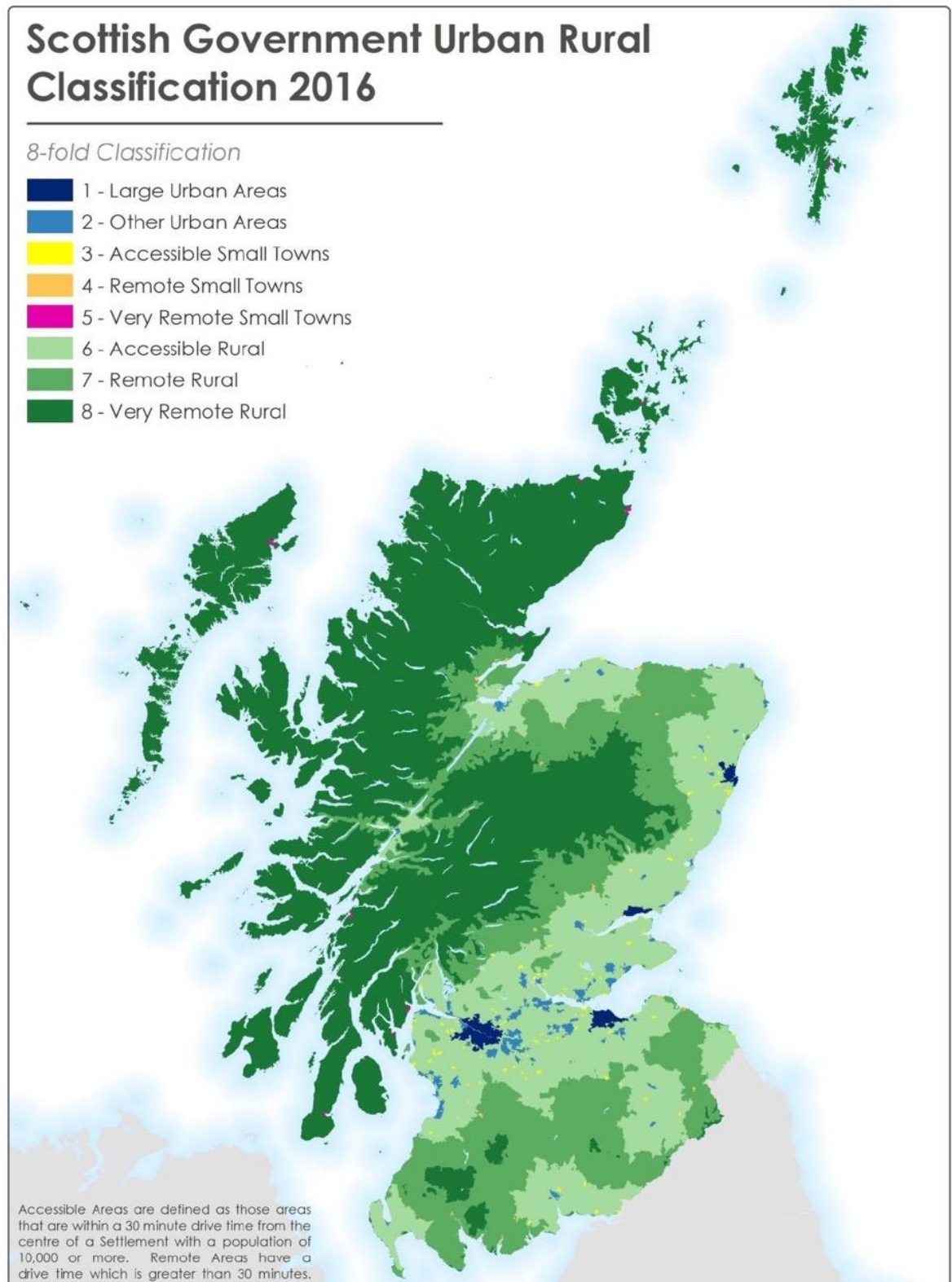
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Appendices

Appendix 1



Appendix 2

Clinical Skills teaching by mentors in rural Scotland'. Research study by Tamsin Smith, PEF, NHS Western Isles

Information for Participants

Thank you for considering participating in this research study. Please read the following information carefully and be sure to ask any questions before signing the consent form. You are under no obligation to take part in the study and no questions will be asked if you choose not to.

Aim of the study

I am interested in the experiences of mentors teaching pre-registration nursing students whilst in their practice area on placement within the Western Isles. I am keen to find out about the work mentors are doing in teaching students and hear about your experiences in this rural area of Scotland.

What would I have to do?

You will be asked to take part in either an in-depth semi-structured interview or a focus group with other mentors and the questions asked will include asking you to describe your experiences of teaching clinical skills to student nurses.

Interviews and focus groups will be undertaken away from the clinical area whenever possible. Once the interview or focus group has taken place, I will transcribe the conversation and you will have the opportunity to view this. You will be able to remove or change any information you are not happy with.

What sort of questions will be asked?

The planned questions include:

- How long have you been a mentor?
- What initial mentor preparation did you undertake?
- When was your last mentor update?
- How many students have you mentored in the past three years?
- What do you teach student nurses when they are in your clinical area?
- How do you teach student nurses?
- Can you tell me about a time when you were teaching a student nurse in your clinical area?

- Are there any challenges to teaching student nurses in clinical practice?
- What are the positive aspects of teaching student nurses in your clinical area?
- What skills do you think mentors need to teach student nurses in clinical practice?

However, as the interviews and focus groups are semi-structured and narrative in nature, these questions are only a guide. The most important aspect is that you feel able to talk about your experiences.

Consent

You will be asked to give written consent to take part in the research. You will be free to withdraw from the project at any time without adverse consequences and you don't have to give a reason for this. If you do withdraw your data will be removed and destroyed.

How will the information I give be protected?

Your data will be protected under the Data Protection Act (2003). The audio recordings and transcripts will be stored securely in a locked file. Data must be kept for ten years and then it will be destroyed.

How will my identity be protected?

Interviews and focus groups will be undertaken away from clinical areas wherever possible and information will be anonymised.

Confidentiality

If you disclose information during the course of an interview that is personal, and you wish to remain confidential then this will be kept confidential and not disclosed to any other person or be published. However, you must also be aware that if you disclose an issue of poor or unsafe practice I am professionally bound by the Nursing and Midwifery Council to disclose this. I will encourage you to speak to the appropriate person or use the appropriate reporting mechanism initially but may have to report a safeguarding incident if you do not.

Where will my information be presented?

The data from this project will form part of my Doctorate in Education and therefore will be seen by my supervisor, co-supervisor and those marking my work. The research will be presented to the Open University and a copy will be kept in the Open University library in Milton Keynes and may be accessible online. The research may also be published in nursing and educational journals. However, the information you have given will be anonymised before it is included in the study.

Raising Concerns or Complaints

If you want to make a complaint or raise concerns about how the research is being carried out, you can contact:

Dr Inma Alvarez

EdD Programme Leader

Faculty of Education and Language Studies

Centre for Research in Education and Educational technology

The Open University

Stuart Hall Building (Ground Floor)

Walton Hall

Milton Keynes

MK7 6AA

Thank you for taking the time to read this information. I am happy to answer any further questions that you may have. Please take your time in deciding whether to take part in this study and contact me when you are ready to make a decision either way.

Tamsin Smith

PEF

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Email: [XXXXXXXXXXXX](#)

Phone: xxxxxx

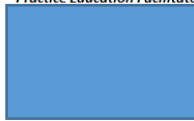
Appendix 3



Consent Form

'Clinical skills teaching by mentors in rural Scotland'

Tamsin Smith
Practice Education Facilitator



1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason ☐
3. I understand that I may choose whether to participate in an individual interview or focus group ☐
4. I agree to the interview being audio recorded ☐
5. I agree to the use of anonymised quotes being used in publication ☐
6. I agree to take part in the above study ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Please return consent form to the above address marked 'CONFIDENTIAL'